111TH CONGRESS
1ST SESSION

S. 1262

To amend title VII of the Public Health Service Act and titles XVIII and XIX of the Social Security Act to provide additional resources for primary care services, to create new payment models for services under Medicare, to expand provision of non-institutionally-based long-term services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 15, 2009

Ms. CANTWELL introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title VII of the Public Health Service Act and titles XVIII and XIX of the Social Security Act to provide additional resources for primary care services, to create new payment models for services under Medicare, to expand provision of non-institutionally-based long-term services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Efficiency and Delivery Improvement of Care Act (MEDIC) of 2009''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—LOAN PROGRAM PROVISIONS

SEC. 1001. SHORT TITLE.

This title may be cited as the ''Physician Workforce Enhancement Act of 2009''.

SEC. 1002. HOSPITAL RESIDENCY LOAN PROGRAM.

Subpart 2 of part E of title VII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 771. HOSPITAL RESIDENCY LOAN PROGRAM.

''(a) ESTABLISHMENT.—Not later than January 1, 2010, the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a loan program that provides loans to eligible hospitals to establish residency training programs.

''(b) APPLICATION.—No loan may be provided under this section to an eligible hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Administrator of the Health Resources and Services Administration. A loan under this section shall be on such terms and conditions and meet

such requirements as the Administrator determines appropriate, in accordance with the provisions of this section.

''(c) ELIGIBILITY; PREFERENCE FOR RURAL AND SMALL URBAN AREAS.—

''(1) ELIGIBLE HOSPITAL DEFINED.—For purposes of this section, an 'eligible hospital' means, with respect to a loan under this section, a hospital that, as of the date of the submission of an application under subsection (b), meets, to the satisfaction of the Administrator of the Health Resources and Services Administration, each of the following criteria:

''(A) The hospital does not operate a residency training program, has not previously operated such a program, and has not taken any significant action, such as the expenditure of a material amount of funds, before July 1, 2009, to establish such a program.

''(B) The hospital has secured initial accreditation by the American Council for Graduate Medical Education or the American Osteopathic Association.

''(C) The hospital provides assurances to the satisfaction of the Administrator of the Health Resources and Services Administration

that such loan shall be used, consistent with subsection (d), only for the purposes of establishing and conducting an allopathic or osteopathic physician residency training program in at least one of the following medical specialties, or a combination of the following:

''(i) Family medicine.

''(ii) Internal medicine.

''(iii) Emergency medicine.

''(iv) Obstetrics or gynecology.

''(v) General surgery.

''(vi) Preventive Medicine.

''(vii) Pediatrics.

''(viii) Behavioral and Mental Health.

''(D) The hospital enters into an agreement with the Administrator that certifies the hospital will provide for the repayment of the loan in accordance with subsection (e).

''(2) PREFERENCE FOR RURAL AND SMALL AREAS.—In making loans under this section, the Administrator of the Health Resources and Services Administration shall give preference to any applicant for such a loan that is a hospital located in a rural areas (as such term is defined in section 1886(d)(2)(D) of the Social Security Act) or an

urban area that is not a large urban area (as such terms are respectively defined in such section).

''(d) PERMISSIBLE USES OF LOAN FUNDS.—A loan provided under this section shall be used, with respect to a residency training program, only for costs directly attributable to the residency training program, except as otherwise provided by the Administrator of the Health Resources and Services Administration.

''(e) REPAYMENT OF LOANS.—

''(1) REPAYMENT PLANS.—For purposes of subsection (c)(1)(D), a repayment plan for an eligible hospital is in accordance with this subsection if it provides for the repayment of the loan amount in installments, in accordance with a schedule that is agreed to by the Administrator of the Health Resources and Services Administration and the hospital and that is in accordance with this subsection.

''(2) COMMENCEMENT OF REPAYMENT.—Repayment by an eligible hospital of a loan under this section shall commence not later than the date that is 18 months after the date on which the loan amount is disbursed to such hospital.

''(3) REPAYMENT PERIOD.—A loan made under this section shall be fully repaid not later than the

date that is 24 months after the date on which the repayment is required to commence.

''(4) LOAN PAYABLE IN FULL IF RESIDENCY TRAINING PROGRAM CANCELED.—In the case that an eligible hospital borrows a loan under this section, with respect to a residency training program, and terminates such program before the date on which such loan has been fully repaid in accordance with a plan under paragraph (1), such loan shall be payable by the hospital not later than 45 days after the date of such termination.

''(f) NO INTEREST CHARGED.—The Administrator of the Health Resources and Services Administration may not charge or collect interest on any loan made under this section.

''(g) LIMITATION ON TOTAL AMOUNT OF LOAN.—The cumulative dollar amount of a loan made to an eligible hospital under this section may not exceed $1,000,000.

''(h) PENALTIES.—The Administrator of the Health Resources and Services Administration shall establish penalties to which an eligible hospital receiving a loan under this section would be subject if such hospital is in violation of any of the criteria described in subsection (c)(1).

''(i) REPORTS.—Not later than January 1, 2014, and annually thereafter (before January 2, 2020), the Admin-

istrator of the Health Resources and Services Administration shall submit to Congress a report on the efficacy of the program under this section in increasing the number of residents practicing in each medical specialty described in subsection (c)(1)(C) during such year and the extent to which the program resulted in an increase in the number of available practitioners in each of such medical specialties that serve medically underserved populations.

''(j) FUNDING.——

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of providing amounts for loans under this section, there are authorized to be appropriated $25,000,000 for the period of fiscal years 2010 through 2020.

''(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.

''(3) REPAID LOAN AMOUNTS.—Any amount repaid by, or recovered from, an eligible hospital under this section on or before the date of termination described in subsection (k) shall be credited to the appropriation account from which the loan amount involved was originally paid. Any amount repaid by, or recovered from, such a hospital under this section

after such date shall be credited to the general fund in the Treasury.

''(k) TERMINATION OF PROGRAM.—No loan may be made under this section after December 31, 2019.''.

TITLE II—PRIMARY CARE PROVISIONS

SEC. 2001. SHORT TITLE.

This title may be cited as the ''Preserving Patient Access to Primary Care Act of 2009''.

SEC. 2002. FINDINGS.

Congress makes the following findings:

(1) Approximately 21 percent of physicians who were board certified in general internal medicine during the early 1990s have left internal medicine, compared to a 5 percent departure rate for those who were certified in subspecialties of internal medicine.

(2) The number of United States medical graduates going into family medicine has fallen by more than 50 percent from 1997 to 2005.

(3) In 2007, only 88 percent of the available medicine residency positions were filled and only 42 percent of those were filled by United States medical school graduates.

(4) In 2006, only 24 percent of third-year internal medicine resident intended to pursue careers in general internal medicine, down from 54 percent in 1998.

(5) Primary care physicians serve as the point of first contact for most patients and are able to coordinate the care of the whole person, reducing unnecessary care and duplicative testing.

(6) Primary care physicians and primary care providers practicing preventive care, including screening for illness and treating diseases, can help prevent complications that result in more costly care.

(7) Patients with primary care physicians or primary care providers have lower health care expenditures and primary care is correlated with better health status, lower overall mortality, and longer life expectancy.

(8) Higher proportions of primary care physicians are associated with significantly reduced utilization.

(9) The United States has a higher ratio of specialists to primary care physicians than other industrialized nations and the population of the United

States is growing faster than the expected rate of growth in the supply of primary care physicians.

(10) The number of Americans age 65 and older, those eligible for Medicare and who use far more ambulatory care visits per person as those under age 65, is expected to double from 2000 to 2030.

(11) A decrease in Federal spending to carry out programs authorized by title VII of the Public Health Service Act threatens the viability of one of the programs used to solve the problem of inadequate access to primary care.

(12) The National Health Service Corps program has a proven record of supplying physicians to underserved areas, and has played an important role in expanding access for underserved populations in rural and inner city communities.

(13) Individuals in many geographic areas, especially rural areas, lack adequate access to high quality preventive, primary health care, contributing to significant health disparities that impair America's public health and economic productivity.

(14) About 20 percent of the population of the United States resides in primary medical care Health Professional Shortage Areas.

SEC. 2003. DEFINITIONS.

(a) GENERAL DEFINITIONS.—In this title:

(1) CHRONIC CARE COORDINATION.—The term ''chronic care coordination'' means the coordination of services that is based on the Chronic Care Model that provides on-going health care to patients with chronic diseases that may include any of the following services:

(A) The development of an initial plan of care, and subsequent appropriate revisions to such plan of care.

(B) The management of, and referral for, medical and other health services, including interdisciplinary care conferences and management with other providers.

(C) The monitoring and management of medications.

(D) Patient education and counseling services.

(E) Family caregiver education and counseling services.

(F) Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.

(G) Providing access by telephone with physicians and other appropriate health care

professionals, including 24-hour availability of such professionals for emergencies.

(H) Management with the principal non-professional caregiver in the home.

(I) Managing and facilitating transitions among health care professionals and across settings of care, including the following:

(i) Pursuing the treatment option elected by the individual.

(ii) Including any advance directive executed by the individual in the medical file of the individual.

(J) Information about, and referral to, hospice care, including patient and family caregiver education and counseling about hospice care, and facilitating transition to hospice care when elected.

(K) Information about, referral to, and management with, community services.

(2) CRITICAL SHORTAGE HEALTH FACILITY.—The term ''critical shortage health facility'' means a public or private nonprofit health facility that does not serve a health professional shortage area (as designated under section 332 of the Public Health Service Act), but that has a critical shortage of phy-

sicians (as determined by the Secretary) in a primary care field.

(3) PHYSICIAN.—The term physician has the meaning given such term in section 1861(r)(1) of the Social Security Act.

(4) PRIMARY CARE.—The term ''primary care'' means the provision of integrated, high-quality, accessible health care services by health care providers who are accountable for addressing a full range of personal health and health care needs, developing a sustained partnership with patients, practicing in the context of family and community, and working to minimize disparities across population subgroups.

(5) PRIMARY CARE FIELD.—The term ''primary care field'' means any of the following fields:

(A) The field of family medicine.

(B) The field of general internal medicine.

(C) The field of geriatric medicine.

(D) The field of pediatric medicine

(6) PRIMARY CARE PHYSICIAN.—The term ''primary care physician'' means a physician who is trained in a primary care field who provides first contact, continuous, and comprehensive care to patients.

(7) PRIMARY CARE PROVIDER.—The term ''primary care provider'' means—

(A) a nurse practitioner; or

(B) a physician assistant practicing as a member of a physician-directed team;

who provides first contact, continuous, and comprehensive care to patients.

(8) PRINCIPAL CARE.—The term ''principal care'' means integrated, accessible health care that is provided by a physician who is a medical subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management, developing a sustained physician-patient partnership and practicing within the context of family and community.

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(b) PRIMARY MEDICAL CARE SHORTAGE AREA.—

(1) IN GENERAL.—In this title, the term ''primary medical care shortage area'' or ''PMCSA'' means a geographic area with a shortage of physicians (as designated by the Secretary) in a primary

care field, as designated in accordance with paragraph (2).

(2) DESIGNATION.—To be designated by the Secretary as a PMCSA, the Secretary must find that the geographic area involved has an established shortage of primary care physicians for the population served. The Secretary shall make such a designation with respect to an urban or rural geographic area if the following criteria are met:

(A) The area is a rational area for the delivery of primary care services.

(B) One of the following conditions prevails within the area:

(i) The area has a population to full-time-equivalent primary care physician ratio of at least 3,500 to 1.

(ii) The area has a population to full-time-equivalent primary care physician ratio of less than 3,500 to 1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.

(C) Primary care providers in contiguous geographic areas are overutilized.

(c) MEDICALLY UNDERSERVED AREA.—

(1) IN GENERAL.—In this title, the term ''medically underserved area'' or ''MUA'' means a rational service area with a demonstrable shortage of primary healthcare resources relative to the needs of the entire population within the service area as determined in accordance with paragraph (2) through the use of the Index of Medical Underservice (referred to in this subsection as the ''IMU'') with respect to data on a service area.

(2) DETERMINATIONS.—Under criteria to be established by the Secretary with respect to the IMU, if a service area is determined by the Secretary to have a score of 62.0 or less, such area shall be eligible to be designated as a MUA.

(3) IMU VARIABLES.—In establishing criteria under paragraph (2), the Secretary shall ensure that the following variables are utilized:

(A) The ratio of primary medical care physicians per 1,000 individuals in the population of the area involved.

(B) The infant mortality rate in the area involved.

(C) The percentage of the population involved with incomes below the poverty level.

(D) The percentage of the population involved age 65 or over.

The value of each of such variables for the service area involved shall be converted by the Secretary to a weighted value, according to established criteria, and added together to obtain the area's IMU score.

(d) PATIENT-CENTERED MEDICAL HOME.—

(1) IN GENERAL.—In this title, the term ''patient-centered medical home'' means a physician-directed practice (or a nurse practitioner directed practice in those States in which such functions are included in the scope of practice of licensed nurse practitioners) that has been certified by an organization under paragraph (3) as meeting the following standards:

(A) The practice provides patients who elect to obtain care through a patient-centered medical home (referred to as ''participating patients'') with direct and ongoing access to a primary or principal care physician or a primary care provider who accepts responsibility for providing first contact, continuous, and comprehensive care to the whole person, in collaboration with teams of other health professionals, includ-

ing nurses and specialist physicians, as needed and appropriate.

(B) The practice applies standards for access to care and communication with participating beneficiaries.

(C) The practice has readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically.

(D) The practice maintains continuous relationships with participating patients by implementing evidence-based guidelines and applying such guidelines to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries.

(2) RECOGNITION OF NCQA APPROVAL.—Such term also includes a physician-directed (or nurse-practitioner-directed) practice that has been recognized as a medical home through the Physician Practice Connections—patient-centered Medical Home (''PPC–PCMH'') voluntary recognition process of the National Committee for Quality Assurance.

(3) STANDARD SETTING AND QUALIFICATION PROCESS FOR MEDICAL HOMES.—The Secretary

shall establish a process for the selection of a qualified standard setting and certification organization—

(A) to establish standards, consistent with this subsection, to enable medical practices to qualify as patient-centered medical homes; and

(B) to provide for the review and certification of medical practices as meeting such standards.

(4) TREATMENT OF CERTAIN PRACTICES.—Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient-centered medical home so long as—

(A) all of the requirements of this section are met; and

(B) the nurse practitioner is acting consistently with State law.

(e) APPLICATION UNDER MEDICARE, MEDICAID, PHSA, ETC.—Unless otherwise provided, the provisions of the previous subsections shall apply for purposes of provisions of the Social Security Act, the Public Health Service Act, and any other Act amended by this title.

Subtitle A—Medical Education

SEC. 2101. RECRUITMENT INCENTIVES.

Title VII of the Higher Education Act of 1965 (20 U.S.C. 1133 et seq.) is amended by adding at the end the following:

"PART VI—MEDICAL EDUCATION RECRUITMENT INCENTIVES

"SEC. 786. MEDICAL EDUCATION RECRUITMENT INCENTIVES.

''(a) IN GENERAL.—The Secretary is authorized to award grants or contracts to institutions of higher education that are graduate medical schools, to enable the graduate medical schools to improve primary care education and training for medical students.

''(b) APPLICATION.—A graduate medical school that desires to receive a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USES OF FUNDS.—A graduate medical school that receives a grant under this section shall use such grant funds to carry out 1 or more of the following:

''(1) The creation of primary care mentorship programs.

''(2) Curriculum development for population-based primary care models of care, such as the patient-centered medical home.

''(3) Increased opportunities for ambulatory, community-based training.

''(4) Development of generalist curriculum to enhance care for rural and underserved populations in primary care or general surgery.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $50,000,000 for each of the fiscal years 2010 through 2012.''.

SEC. 2102. DEBT FORGIVENESS, SCHOLARSHIPS, AND SERVICE OBLIGATIONS.

(a) PURPOSE.—It is the purpose of this section to encourage individuals to enter and continue in primary care physician careers.

(b) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart XX—Primary Care Medical Education

''SEC. 340A. SCHOLARSHIPS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services

Administration, shall award grants to critical shortage health facilities to enable such facilities to provide scholarships to individuals who agree to serve as physicians at such facilities after completing a residency in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009).

''(b) SCHOLARSHIPS.—A health facility shall use amounts received under a grant under this section to enter into contracts with eligible individuals under which—

''(1) the facility agrees to provide the individual with a scholarship for each school year (not to exceed 4 school years) in which the individual is enrolled as a full-time student in a school of medicine or a school of osteopathic medicine; and

''(2) the individual agrees—

''(A) to maintain an acceptable level of academic standing;

''(B) to complete a residency in a primary care field; and

''(C) after completing the residency, to serve as a primary care physician at such facility in such field for a time period equal to the greater of—

"(i) one year for each school year for which the individual was provided a scholarship under this section; or

"(ii) two years.

"(c) AMOUNT.—

"(1) IN GENERAL.—The amount paid by a health facility to an individual under a scholarship under this section shall not exceed $35,000 for any school year.

"(2) CONSIDERATIONS.—In determining the amount of a scholarship to be provided to an individual under this section, a health facility may take into consideration the individual's financial need, geographic differences, and educational costs.

"(3) EXCLUSION FROM GROSS INCOME.—For purposes of the Internal Revenue Code of 1986, gross income shall not include any amount received as a scholarship under this section.

"(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the program established in subsection (a) in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established in such subpart.

''(e) DEFINITIONS.—In this section:

''(1) CRITICAL SHORTAGE HEALTH FACILITY.—The term 'critical shortage health facility' means a public or private nonprofit health facility that does not serve a health professional shortage area (as designated under section 332), but has a critical shortage of physicians (as determined by the Secretary) in a primary care field.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is enrolled, or accepted for enrollment, as a full-time student in an accredited school of medicine or school of osteopathic medicine.

"SEC. 340B. LOAN REPAYMENT PROGRAM.

''(a) PURPOSE.—It is the purpose of this section to alleviate critical shortages of primary care physicians and primary care providers.

''(b) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program of entering into contracts with eligible individuals under which—

''(1) the individual agrees to serve—

''(A) as a primary care physician or primary care provider in a primary care field; and

''(B) in an area that is not a health professional shortage area (as designated under section 332), but has a critical shortage of primary care physicians and primary care providers (as determined by the Secretary) in such field; and

''(2) the Secretary agrees to pay, for each year of such service, not more than $35,000 of the principal and interest of the undergraduate or graduate educational loans of the individual.

''(c) SERVICE REQUIREMENT.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, a public or private nonprofit hospital, or any other appropriate health care entity.

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the program established in subsection (a) in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established in such subpart.

''(e) DEFINITION.—In this section, the term 'eligible individual' means—

''(1) an individual with a degree in medicine or osteopathic medicine; or

''(2) a primary care provider (as defined in section 3(a)(7) of the Preserving Patient Access to Primary Care Act of 2009).

''SEC. 340C. LOAN REPAYMENTS FOR PHYSICIANS IN THE FIELDS OF OBSTETRICS AND GYNECOLOGY AND CERTIFIED NURSE MIDWIVES.

''(a) PURPOSE.—It is the purpose of this section to alleviate critical shortages of physicians in the fields of obstetrics and gynecology and certified nurse midwives.

''(b) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program of entering into contracts with eligible individuals under which—

''(1) the individual agrees to serve—

''(A) as a physician in the field of obstetrics and gynecology or as a certified nurse midwife; and

''(B) in an area that is not a health professional shortage area (as designated under section 332), but has a critical shortage of physicians in the fields of obstetrics and gynecology

or certified nurse midwives (as determined by the Secretary), respectively; and

''(2) the Secretary agrees to pay, for each year of such service, not more than $35,000 of the principal and interest of the undergraduate or graduate educational loans of the individual.

''(c) SERVICE REQUIREMENT.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, a public or private nonprofit hospital, or any other appropriate health care entity.

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the program established in subsection (a) in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established in such subpart.

''(e) DEFINITION.—In this section, the term 'eligible individual' means—

''(1) a physician in the field of obstetrics and gynecology; or

''(2) a certified nurse midwife.

"SEC. 340D. REPORTS.

''Not later than 18 months after the date of enactment of this section, and annually thereafter, the Secretary shall submit to Congress a report that describes the programs carried out under this subpart, including statements concerning—

''(1) the number of enrollees, scholarships, loan repayments, and grant recipients;

''(2) the number of graduates;

''(3) the amount of scholarship payments and loan repayments made;

''(4) which educational institution the recipients attended;

''(5) the number and placement location of the scholarship and loan repayment recipients at health care facilities with a critical shortage of primary care physicians;

''(6) the default rate and actions required;

''(7) the amount of outstanding default funds of both the scholarship and loan repayment programs;

''(8) to the extent that it can be determined, the reason for the default;

''(9) the demographics of the individuals participating in the scholarship and loan repayment programs;

''(10) the justification for the allocation of funds between the scholarship and loan repayment programs; and

''(11) an evaluation of the overall costs and benefits of the programs.

''SEC. 340E. AUTHORIZATION OF APPROPRIATIONS.

''To carry out sections 340I, 340J, and 340K there are authorized to be appropriated $55,000,000 for fiscal year 2010, $90,000,000 for fiscal year 2011, and $125,000,000 for fiscal year 2012, to be used solely for scholarships and loan repayment awards for primary care physicians and primary care providers.''.

SEC. 2103. DEFERMENT OF LOANS DURING RESIDENCY AND INTERNSHIPS.

(a) LOAN REQUIREMENTS.—Section 427(a)(2)(C)(i) of the Higher Education Act of 1965 (20 U.S.C. 1077(a)(2)(C)(i)) is amended by inserting ''unless the medical internship or residency program is in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

(b) FFEL LOANS.—Section 428(b)(1)(M)(i) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(M)(i)) is amended by inserting ''unless the medical internship or residency program is in a primary

care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

(c) FEDERAL DIRECT LOANS.—Section 455(f)(2)(A) of the Higher Education Act of 1965 (20 U.S.C. 1087e(f)(2)(A)) is amended by inserting ''unless the medical internship or residency program is in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

(d) FEDERAL PERKINS LOANS.—Section 464(c)(2)(A)(i) of the Higher Education Act of 1965 (20 U.S.C. 1087dd(c)(2)(A)(i)) is amended by inserting ''unless the medical internship or residency program is in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

SEC. 2104. EDUCATING MEDICAL STUDENTS ABOUT PRIMARY CARE CAREERS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k) is amended by adding at the end the following:

"SEC. 749. EDUCATING MEDICAL STUDENTS ABOUT PRIMARY CARE CAREERS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible State and local government entities for the development of informational materials that promote careers in primary care by highlighting the advantages and rewards of primary care, and that encourage medical students, particularly students from disadvantaged backgrounds, to become primary care physicians.

''(b) ANNOUNCEMENT.—The grants described in subsection (a) shall be announced through a publication in the Federal Register and through appropriate media outlets in a manner intended to reach medical education institutions, associations, physician groups, and others who communicate with medical students.

''(c) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

''(1) be a State or local entity; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—An entity shall use amounts received under a grant under this section to support State and local campaigns through appropriate media outlets to promote careers in primary

care and to encourage individuals from disadvantaged backgrounds to enter and pursue careers in primary care.

''(2) SPECIFIC USES.—In carrying out activities under paragraph (1), an entity shall use grants funds to develop informational materials in a manner intended to reach as wide and diverse an audience of medical students as possible, in order to—

''(A) advertise and promote careers in primary care;

''(B) promote primary care medical education programs;

''(C) inform the public of financial assistance regarding such education programs;

''(D) highlight individuals in the community who are practicing primary care physicians; or

''(E) provide any other information to recruit individuals for careers in primary care.

''(e) LIMITATION.—An entity shall not use amounts received under a grant under this section to advertise particular employment opportunities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section,

such sums as may be necessary for each of fiscal years 2010 through 2013.''.

SEC. 2105. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL GERIATRICS, GENERAL PEDIATRICS, PHYSICIAN ASSISTANT EDUCATION, GENERAL DENTISTRY, AND PEDIATRIC DENTISTRY.

Section 747(e) of the Public Health Service Act (42 U.S.C. 293k) is amended by striking paragraph (1) and inserting the following:

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $198,000,000 for each of fiscal years 2010 through 2012.''.

SEC. 2106. INCREASED FUNDING FOR NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

(a) IN GENERAL.—There is authorized to be appropriated $332,000,000 for the period of fiscal years 2010 through 2012 for the purpose of carrying out subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.). Such authorization of appropriations is in addition to the authorization of appropriations in section 338H of such Act (42 U.S.C. 254q) and any other authorization of appropriations for such purpose.

(b) ALLOCATION.—Of the amounts appropriated under subsection (a) for the period of fiscal years 2010 through 2012, the Secretary shall obligate $96,000,000 for the purpose of providing contracts for scholarships and loan repayments to individuals who—

(1) are primary care physicians or primary care providers; and

(2) have not previously received a scholarship or loan repayment under subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.).

Subtitle B—Medicaid Related Provisions

SEC. 2201. TRANSFORMATION GRANTS TO SUPPORT PATIENT-CENTERED MEDICAL HOMES UNDER MEDICAID AND CHIP.

(a) IN GENERAL.—Section 1903(z) of the Social Security Act (42 U.S.C. 1396b(z)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

"(G) Methods for improving the effectiveness and efficiency of medical assistance provided under this title and child health assistance provided under title XXI by encouraging the adoption of medical practices that satisfy

the standards established by the Secretary under paragraph (2) of section 3(d) of the Preserving Patient Access to Primary Care Act of 2009 for medical practices to qualify as patient-centered medical homes (as defined in paragraph (1) of such section).''; and

(2) in paragraph (4)—

(A) in subparagraph (A)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after clause (ii), the following new clause:

''(iii) $25,000,000 for each of fiscal years 2010, 2011, and 2012.''; and

(B) in subparagraph (B), by striking the second and third sentences and inserting the following: ''Such method shall provide that 100 percent of such funds for each of fiscal years 2010, 2011, and 2012 shall be allocated among States that design programs to adopt the innovative methods described in paragraph (2)(G), with preference given to States that design programs involving multipayers (including under

title XVIII and private health plans) test projects for implementation of the elements necessary to be recognized as a patient-centered medical home practice under the National Committee for Quality Assurance Physicians Practice Connection—PCMH module (or any other equivalent process, as determined by the Secretary).''.

(b) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

Subtitle C—Medicare Provisions

PART I—PRIMARY CARE

SEC. 2301. REFORMING PAYMENT SYSTEMS UNDER MEDICARE TO SUPPORT PRIMARY CARE.

(a) INCREASING BUDGET NEUTRALITY LIMITS UNDER THE PHYSICIAN FEE SCHEDULE TO ACCOUNT FOR ANTICIPATED SAVINGS RESULTING FROM PAYMENTS FOR CERTAIN SERVICES AND THE COORDINATION OF BENEFICIARY CARE.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended—

(1) in clause (ii)(II), by striking ''(iv) and (v)'' and inserting ''(iv), (v), and (vii)''; and

(2) by adding at the end the following new clause:

"(vii) INCREASE IN LIMITATION TO ACCOUNT FOR CERTAIN ANTICIPATED SAVINGS.—

"(I) IN GENERAL.—Effective for fee schedules established beginning with 2010, the Secretary shall increase the limitation on annual adjustments under clause (ii)(II) by an amount equal to the anticipated savings under parts A, B, and D (including any savings with respect to items and services for which payment is not made under this section) which are a result of payments for designated primary care services and comprehensive care coordination services under section 1834(m) and the coverage of patient-centered medical home services under section 1861(s)(2)(FF) (as determined by the Secretary).

"(II) MECHANISM TO DETERMINE APPLICATION OF INCREASE.—The Secretary shall establish a mechanism for determining which relative value units established under this

paragraph for physicians' services shall be subject to an adjustment under clause (ii)(I) as a result of the increase under subclause (I).

"(III) ADDITIONAL FUNDING AS DETERMINED NECESSARY BY THE SECRETARY.—In addition to any funding that may be made available as a result of an increase in the limitation on annual adjustments under subclause (I), there shall also be available to the Secretary, for purposes of making payments under this title for new services and capabilities to improve care provided to individuals under this title and to generate efficiencies under this title, such additional funds as the Secretary determines are necessary.".

(b) SEPARATE MEDICARE PAYMENT FOR DESIGNATED PRIMARY CARE SERVICES AND COMPREHENSIVE CARE COORDINATION SERVICES.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) PAYMENT FOR DESIGNATED PRIMARY CARE SERVICES AND COMPREHENSIVE CARE COORDINATION SERVICES.—

''(1) IN GENERAL.—The Secretary shall pay for designated primary care services and comprehensive care coordination services furnished to an individual enrolled under this part.

''(2) PAYMENT AMOUNT.—The Secretary shall determine the amount of payment for designated primary care services and comprehensive care coordination services under this subsection.

''(3) DOCUMENTATION REQUIREMENTS.—The Secretary shall propose appropriate documentation requirements to justify payments for designated primary care services and comprehensive care coordination services under this subsection.

''(4) DEFINITIONS.—

''(A) COMPREHENSIVE CARE COORDINATION SERVICES.—The term 'comprehensive care coordination services' means care coordination services with procedure codes established by the Secretary (as appropriate) which are furnished to an individual enrolled under this part by a primary care provider or principal care physician.

''(B) DESIGNATED PRIMARY CARE SERVICES.—The term 'designated primary care service' means a service which the Secretary determines has a procedure code which involves a clinical interaction with an individual enrolled under this part that is inherent to care coordination, including interactions outside of a face-to-face encounter. Such term includes the following:

''(i) Care plan oversight.

''(ii) Evaluation and management provided by phone.

''(iii) Evaluation and management provided using internet resources.

''(iv) Collection and review of physiologic data, such as from a remote monitoring device.

''(v) Education and training for patient self management.

''(vi) Anticoagulation management services.

''(vii) Any other service determined appropriate by the Secretary.''.

(2) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services furnished on or after January 1, 2010.

SEC. 2302. COVERAGE OF PATIENT-CENTERED MEDICAL HOME SERVICES.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (DD), by striking ''and'' at the end;

(2) in subparagraph (EE), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(FF) patient-centered medical home services (as defined in subsection (hhh)(1));''.

(b) DEFINITION OF PATIENT-CENTERED MEDICAL HOME SERVICES.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Patient-Centered Medical Home Services

''(hhh)(1) The term 'patient-centered medical home services' means care coordination services furnished by a qualified patient-centered medical home.

''(2) The term 'qualified patient-centered medical home' means a patient-centered medical home (as defined

in section 3(d) of the Preserving Patient Access to Primary Care Act of 2009).''.

(c) MONTHLY FEE FOR PATIENT-CENTERED MEDICAL HOME SERVICES.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(p) MONTHLY FEE FOR PATIENT-CENTERED MEDICAL HOME SERVICES.—

''(1) MONTHLY FEE.—

''(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a payment methodology for patient-centered medical home services (as defined in paragraph (1) of section 1861(hhh)). Under such payment methodology, the Secretary shall pay qualified patient-centered medical homes (as defined in paragraph (2) of such section) a monthly fee for each individual who elects to receive patient-centered medical home services at that medical home. Such fee shall be paid on a prospective basis.

''(B) CONSIDERATIONS.—The Secretary shall take into account the results of the Medicare medical home demonstration project under section 204 of the Medicare Improvement and

Extension Act of 2006 (42 U.S.C. 1395b–1 note; division B of Public Law 109–432) in establishing the payment methodology under subparagraph (A).

''(2) AMOUNT OF PAYMENT.—

''(A) CONSIDERATIONS.—In determining the amount of such fee, subject to paragraph (3), the Secretary shall consider the following:

''(i) The clinical work and practice expenses involved in providing care coordination services consistent with the patient-centered medical home model (such as providing increased access, care coordination, disease population management, and education) for which payment is not made under this section as of the date of enactment of this subsection.

''(ii) Ensuring that the amount of payment is sufficient to support the acquisition, use, and maintenance of clinical information systems which—

''(I) are needed by a qualified patient-centered medical home; and

''(II) have been shown to facilitate improved outcomes through care coordination.

''(iii) The establishment of a tiered monthly care management fee that provides for a range of payment depending on how advanced the capabilities of a qualified patient-centered medical home are in having the information systems needed to support care coordination.

''(B) RISK-ADJUSTMENT.—The Secretary shall use appropriate risk-adjustment in determining the amount of the monthly fee under this paragraph.

''(3) FUNDING.—

''(A) IN GENERAL.—The Secretary shall determine the aggregate estimated savings for a calendar year as a result of the implementation of this subsection on reducing preventable hospital admissions, duplicate testing, medication errors and drug interactions, and other savings under this part and part A (including any savings with respect to items and services for which payment is not made under this section).

"(B) FUNDING.—Subject to subparagraph (C), the aggregate amount available for payment of the monthly fee under this subsection during a calendar year shall be equal to the aggregate estimated savings (as determined under subparagraph (A)) for the calendar year (as determined by the Secretary).

"(C) ADDITIONAL FUNDING.—In the case where the amount of the aggregate actual savings during the preceding 3 years exceeds the amount of the aggregate estimated savings (as determined under subparagraph (A)) during such period, the aggregate amount available for payment of the monthly fee under this subsection during the calendar year (as determined under subparagraph (B)) shall be increased by the amount of such excess.

"(D) ADDITIONAL FUNDING AS DETERMINED NECESSARY BY THE SECRETARY.—In addition to any funding made available under subparagraphs (B) and (C), there shall also be available to the Secretary, for purposes of effectively implementing this subsection, such additional funds as the Secretary determines are necessary.

''(4) PERFORMANCE-BASED BONUS PAYMENTS.—The Secretary shall establish a process for paying a performance-based bonus to qualified patient-centered medical homes which meet or achieve substantial improvements in performance (as specified under clinical, patient satisfaction, and efficiency benchmarks established by the Secretary). Such bonus shall be in an amount determined appropriate by the Secretary.

''(5) NO EFFECT ON PAYMENTS FOR EVALUATION AND MANAGEMENT SERVICES.—The monthly fee under this subsection shall have no effect on the amount of payment for evaluation and management services under this title.''.

(d) COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and'' before ''(W)''; and

(2) by inserting before the semicolon at the end the following: '', and (X) with respect to patient-centered medical home services (as defined in section 1861(hhh)(1)), the amount paid shall be (i) in the case of such services which are physicians' services, the amount determined under subparagraph (N), and (ii) in the case of all other such services, 80 percent of the lesser of the actual charge for the service

or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2012.

SEC. 2303. MEDICARE PRIMARY CARE PAYMENT EQUITY AND ACCESS PROVISION.

(a) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 2302(c), is amended by adding at the end the following new subsection:

''(q) PRIMARY CARE PAYMENT EQUITY AND ACCESS.—

''(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall develop a methodology, in consultation with primary care physician organizations and primary care provider organizations, the Medicare Payment Advisory Commission, and other experts, to increase payments under this section for designated evaluation and management services provided by primary care physicians, primary care providers, and principal care providers through 1 or more of the following:

''(A) A service-specific modifier to the relative value units established for such services.

''(B) Service-specific bonus payments.

''(C) Any other methodology determined appropriate by the Secretary.

''(2) INCLUSION OF PROPOSED CRITERIA.—The methodology developed under paragraph (1) shall include proposed criteria for providers to qualify for such increased payments, including consideration of—

''(A) the type of service being rendered;

''(B) the specialty of the provider providing the service; and

''(C) demonstration by the provider of voluntary participation in programs to improve quality, such as participation in the Physician Quality Reporting Initiative (as determined by the Secretary) or practice-level qualification as a patient-centered medical home.

''(3) FUNDING.—

''(A) DETERMINATION.—The Secretary shall determine the aggregate estimated savings for a calendar year as a result of such increased payments on reducing preventable hospital admissions, duplicate testing, medication errors

and drug interactions, Intensive Care Unit admissions, per capita health care expenditures, and other savings under this part and part A (including any savings with respect to items and services for which payment is not made under this section).

''(B) FUNDING.—The aggregate amount available for such increased payments during a calendar year shall be equal to the aggregate estimated savings (as determined under subparagraph (A)) for the calendar year (as determined by the Secretary).

''(C) ADDITIONAL FUNDING AS DETERMINED NECESSARY BY THE SECRETARY.—In addition to any funding made available under subparagraph (B), there shall also be available to the Secretary, for purposes of effectively implementing this subsection, such additional funds as the Secretary determines are necessary.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 2304. ADDITIONAL INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(x) ADDITIONAL INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2010, by a primary care physician or primary care provider in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection:

''(A) PRIMARY CARE PHYSICIAN; PRIMARY CARE PROVIDER.—The terms 'primary care physician' and 'primary care provider' have the

meaning given such terms in paragraphs (6) and (7), respectively, of section 3(a) of the Preserving Patient Access to Primary Care Act of 2009.

''(B) PRIMARY CARE SERVICES.—The term 'primary care services' means procedure codes for services in the category of the Healthcare Common Procedure Coding System, as established by the Secretary under section 1848(c)(5) (as of December 31, 2008, and as subsequently modified by the Secretary) consisting of evaluation and management services, but limited to such procedure codes in the category of office or other outpatient services, and consisting of subcategories of such procedure codes for services for both new and established patients.

''(3) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care physicians, primary care providers, or primary care services under this subsection.''.

(b) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the fol-

lowing sentence: ''Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.''.

SEC. 2305. PERMANENT EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS.

Section 1833(u) of the Social Security Act (42 U.S.C. 1395l(u)) is amended—

(1) in paragraph (1)—

(A) by inserting ''or on or after July 1, 2009'' after ''before July 1, 2008''; and

(B) by inserting ''(or, in the case of services furnished on or after July 1, 2009, 10 percent)'' after ''5 percent''; and

(2) in paragraph (4)(D), by striking ''before July 1, 2008'' and inserting ''before January 1, 2010''.

SEC. 2306. HHS STUDY AND REPORT ON THE PROCESS FOR DETERMINING RELATIVE VALUE UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) STUDY.—The Secretary shall conduct a study on the process used by the Secretary for determining relative value under the Medicare physician fee schedule under section 1848(c) of the Social Security Act (42 U.S.C.

1395w–4(c)). Such study shall include an analysis of the following:

(1)(A) Whether the existing process includes equitable representation of primary care physicians (as defined in section 2003(a)(6)); and

(B) any changes that may be necessary to ensure such equitable representation.

(2)(A) Whether the existing process provides the Secretary with expert and impartial input from physicians in medical specialties that provide primary care to patients with multiple chronic diseases, the fastest growing part of the Medicare population; and

(B) any changes that may be necessary to ensure such input.

(3)(A) Whether the existing process includes equitable representation of physician medical specialties in proportion to their relative contributions toward caring for Medicare beneficiaries, as determined by the percentage of Medicare billings per specialty, percentage of Medicare encounters by specialty, or such other measures of relative contributions to patient care as determined by the Secretary; and

(B) any changes that may be necessary to reflect such equitable representation.

(4)(A) Whether the existing process, including the application of budget neutrality rules, unfairly disadvantages primary care physicians, primary care providers, or other physicians who principally provide evaluation and management services; and

(B) any changes that may be necessary to eliminate such disadvantages.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—PREVENTIVE SERVICES

SEC. 2311. ELIMINATING TIME RESTRICTION FOR INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) IN GENERAL.—Section 1862(a)(1)(K) of the Social Security Act (42 U.S.C. 1395y(a)(1)(K)) is amended by striking ''more than'' and all that follows before the comma at the end and inserting ''more than one time during the lifetime of the individual''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 2312. ELIMINATION OF COST-SHARING FOR PREVENTIVE BENEFITS UNDER THE MEDICARE PROGRAM.

(a) DEFINITION OF PREVENTIVE SERVICES.—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395w(dd)) is amended—

(1) in the heading, by inserting ''; Preventive Services'' after ''Services'';

(2) in paragraph (1), by striking ''not otherwise described in this title'' and inserting ''not described in subparagraphs (A) through (N) of paragraph (3)''; and

(3) by adding at the end the following new paragraph:

''(3) The term 'preventive services' means the following:

''(A) Prostate cancer screening tests (as defined in subsection (oo)).

''(B) Colorectal cancer screening tests (as defined in subsection (pp)).

''(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

''(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

''(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

''(F) An initial preventive physical examination (as defined in subsection (ww)).

''(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

''(H) Diabetes screening tests (as defined in subsection (yy)).

''(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in subsection (s)(2)(AA)).

''(J) Pneumococcal and influenza vaccine and their administration (as described in subsection (s)(10)(A)).

''(K) Hepatitis B vaccine and its administration for certain individuals (as described in subsection (s)(10)(B)).

''(L) Screening mammography (as defined in subsection (jj)).

''(M) Screening pap smear and screening pelvic exam (as described in subsection (s)(14)).

''(N) Bone mass measurement (as defined in subsection (rr)).

''(O) Additional preventive services (as determined under paragraph (1)).''.

(b) COINSURANCE.—

(1) GENERAL APPLICATION.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 2302, is amended—

(i) in subparagraph (T), by striking ''80 percent'' and inserting ''100 percent'';

(ii) in subparagraph (W), by striking ''80 percent'' and inserting ''100 percent'';

(iii) by striking ''and'' before ''(X)''; and

(iv) by inserting before the semicolon at the end the following: '', and (Y) with respect to preventive services described in subparagraphs (A) through (O) of section 1861(ddd)(3), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part''.

(2) ELIMINATION OF COINSURANCE FOR SCREENING SIGMOIDOSCOPIES AND COLONOSCOPIES.—Section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by inserting ", except that payment for such tests under such section shall be 100 percent of the payment determined under such section for such tests" before the period at the end; and

(ii) in subparagraph (C)—

(I) by striking clause (ii); and

(II) in clause (i)—

(aa) by striking "(i) IN GENERAL.—Notwithstanding" and inserting "Notwithstanding";

(bb) by redesignating subclauses (I) and (II) as clauses (i) and (ii), respectively, and moving such clauses 2 ems to the left; and

(cc) in the flush matter following clause (ii), as so redesig-

nated, by inserting ''100 percent of'' after ''based on''; and

(B) in paragraph (3)—

(i) in subparagraph (A), by inserting '', except that payment for such tests under such section shall be 100 percent of the payment determined under such section for such tests'' before the period at the end; and

(ii) in subparagraph (C)—

(I) by striking clause (ii); and

(II) in clause (i)—

(aa) by striking ''(i) IN GENERAL.—Notwithstanding'' and inserting ''Notwithstanding''; and

(bb) by inserting ''100 percent of'' after ''based on''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammog-

raphy, and preventive services (as defined in section 1861(ddd)(3))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (G)(ii), by adding ''and'' at the end; and

(iii) by adding at the end the following new subparagraph:

''(H) with respect to preventive services (as defined in section 1861(ddd)(3)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W) or (1)(X), as applicable;''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(1) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services (as defined in section 1861(ddd)(3))'';

(2) by inserting ''and'' before ''(4)''; and

(3) by striking ", (5)" and all that follows up to the period at the end.

SEC. 2313. HHS STUDY AND REPORT ON FACILITATING THE RECEIPT OF MEDICARE PREVENTIVE SERVICES BY MEDICARE BENEFICIARIES.

(a) STUDY.—The Secretary, in consultation with provider organizations and other appropriate stakeholders, shall conduct a study on—

(1) ways to assist primary care physicians and primary care providers (as defined in section 2003(a)) in—

(A) furnishing appropriate preventive services (as defined in section 1861(ddd)(3) of the Social Security Act, as added by section 2312) to individuals enrolled under part B of title XVIII of such Act; and

(B) referring such individuals for other items and services furnished by other physicians and health care providers; and

(2) the advisability and feasability of making additional payments under the Medicare program to physicians and primary care providers for—

(A) the work involved in ensuring that such individuals receive appropriate preventive

services furnished by other physicians and health care providers; and

(B) incorporating the resulting clinical information into the treatment plan for the individual.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—OTHER PROVISIONS

SEC. 2321. HHS STUDY AND REPORT ON IMPROVING THE ABILITY OF PHYSICIANS AND PRIMARY CARE PROVIDERS TO ASSIST MEDICARE BENEFICIARIES IN OBTAINING NEEDED PRESCRIPTIONS UNDER MEDICARE PART D.

(a) STUDY.—The Secretary, in consultation with physician organizations and other appropriate stakeholders, shall conduct a study on the development and implementation of mechanisms to facilitate increased efficiency relating to the role of physicians and primary care providers in Medicare beneficiaries obtaining needed prescription drugs under the Medicare prescription drug program

under part D of title XVIII of the Social Security Act. Such study shall include an analysis of ways to—

(1) improve the accessibility of formulary information;

(2) streamline the prior authorization, exception, and appeals processes, through, at a minimum, standardizing formats and allowing electronic exchange of information; and

(3) recognize the work of the physician and primary care provider involved in the prescribing process, especially work that may extend beyond the amount considered to be bundled into payment for evaluation and management services.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 2322. HHS STUDY AND REPORT ON IMPROVED PATIENT CARE THROUGH INCREASED CAREGIVER AND PHYSICIAN INTERACTION.

(a) STUDY.—The Secretary, in consultation with appropriate stakeholders, shall conduct a study on the development and implementation of mechanisms to promote

and increase interaction between physicians or primary care providers and the families of Medicare beneficiaries, as well as other caregivers who support such beneficiaries, for the purpose of improving patient care under the Medicare program. Such study shall include an analysis of—

(1) ways to recognize the work of physicians and primary care providers involved in discussing clinical issues with caregivers that relate to the care of the beneficiary; and

(2) regulations under the Medicare program that are barriers to interactions between caregivers and physicians or primary care providers and how such regulations should be revised to eliminate such barriers.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 2323. IMPROVED PATIENT CARE THROUGH EXPANDED SUPPORT FOR LIMITED ENGLISH PROFICIENCY (LEP) SERVICES.

(a) ADDITIONAL PAYMENTS FOR PRIMARY CARE PHYSICIANS AND PRIMARY CARE PROVIDERS.—Section

1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section 2304, is amended by adding at the end the following new subsection:

''(y) ADDITIONAL PAYMENTS FOR PROVIDING SERVICES TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.—

''(1) IN GENERAL.—In the case of primary care providers' services furnished on or after January 1, 2010, to an individual with limited English proficiency by a provider, in addition to the amount of payment that would otherwise be made for such services under this part, there shall also be paid an appropriate amount (as determined by the Secretary) in order to recognize the additional time involved in furnishing the service to such individual.

''(2) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the determination of the amount of additional payment under this subsection.''.

(b) NATIONAL CLEARINGHOUSE.—Not later than 180 days after the date of enactment of this Act, the Secretary shall establish a national clearinghouse to make available to the primary care physicians, primary care providers, patients, and States translated documents regard-

ing patient care and education under the Medicare program, the Medicaid program, and the State Children's Health Insurance Program under titles XVIII, XIX, and XXI, respectively, of the Social Security Act.

(c) GRANTS TO SUPPORT LANGUAGE TRANSLATION SERVICES IN UNDERSERVED COMMUNITIES.—

(1) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants to support language translation services for primary care physicians and primary care providers in medically underserved areas (as defined in section 2003(c)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to award grants under this subsection, such sums as are necessary for fiscal years beginning with fiscal year 2010.

SEC. 2324. HHS STUDY AND REPORT ON USE OF REAL-TIME MEDICARE CLAIMS ADJUDICATION.

(a) STUDY.—The Secretary shall conduct a study to assess the ability of the Medicare program under title XVIII of the Social Security Act to engage in real-time claims adjudication for items and services furnished to Medicare beneficiaries.

(b) CONSULTATION.—In conducting the study under subsection (a), the Secretary consult with stakeholders in

the private sector, including stakeholders who are using or are testing real-time claims adjudication systems.

(c) REPORT.—Not later than January 1, 2011, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 2325. ONGOING ASSESSMENT BY MEDPAC OF THE IMPACT OF MEDICARE PAYMENTS ON PRIMARY CARE ACCESS AND EQUITY.

The Medicare Payment Advisory Commission, beginning in 2010 and in each of its subsequent annual reports to Congress on Medicare physician payment policies, shall provide an assessment of the impact of changes in Medicare payment policies in improving access to and equity of payments to primary care physicians and primary care providers. Such assessment shall include an assessment of the effectiveness, once implemented, of the Medicare payment-related reforms required by this Act to support primary care as well as any other payment changes that may be required by Congress to improve access to and equity of payments to primary care physicians and primary care providers.

SEC. 2326. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)''; and

(3) by adding at the end the following new paragraph:

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) ADDITIONAL RESIDENCY POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—The Secretary shall reduce the otherwise applicable resident limit for a hospital that the Secretary determines had residency positions that were unused for all 5 of the most recent cost reporting periods ending prior to the date of enactment of this paragraph by an amount that is equal to the

number of such unused residency positions.

"(II) EXCEPTION FOR RURAL HOSPITALS AND CERTAIN OTHER HOSPITALS.—This subparagraph shall not apply to a hospital—

"(aa) located in a rural area (as defined in subsection (d)(2)(D)(ii));

"(bb) that has participated in a voluntary reduction plan under paragraph (6); or

"(cc) that has participated in a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248.

"(ii) NUMBER AVAILABLE FOR DISTRIBUTION.—The number of additional residency positions available for distribution under subparagraph (B) shall be an amount that the Secretary determines would result in a 15 percent increase in the aggregate number of full-time equivalent residents in approved medical training

programs (as determined based on the most recent cost reports available at the time of distribution). One-third of such number shall only be available for distribution to hospitals described in subclause (I) of subparagraph (B)(ii) under such subparagraph.

''(B) DISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after the date of enactment of this paragraph. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the number of additional residency positions available for distribution under subparagraph (A)(ii).

''(ii) DISTRIBUTION TO HOSPITALS ALREADY OPERATING OVER RESIDENT LIMIT.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital in which the reference resident level of the hospital (as defined in clause (ii)) is greater than the otherwise applicable resident limit, the increase in the otherwise applicable resident limit under this subparagraph shall be an amount equal to the product of the total number of additional residency positions available for distribution under subparagraph (A)(ii) and the quotient of—

"(aa) the number of resident positions by which the reference resident level of the hospital exceeds the otherwise applicable resident limit for the hospital; and

"(bb) the number of resident positions by which the reference resident level of all such hospitals with respect to which an application is approved under this subparagraph exceeds the otherwise

applicable resident limit for such hospitals.

"(II) REQUIREMENTS.—A hospital described in subclause (I)—

"(aa) is not eligible for an increase in the otherwise applicable resident limit under this subparagraph unless the amount by which the reference resident level of the hospital exceeds the otherwise applicable resident limit is not less than 10 and the hospital trains at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery (as of the date of enactment of this paragraph); and

"(bb) shall continue to train at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery for the 10-year period beginning on such date.

In the case where the Secretary determines that a hospital no longer meets the requirement of item (bb), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this clause.

''(III) CLARIFICATION REGARDING ELIGIBILITY FOR OTHER ADDITIONAL RESIDENCY POSITIONS.—Nothing in this clause shall be construed as preventing a hospital described in subclause (I) from applying for additional residency positions under this paragraph that are not reserved for distribution under this clause.

''(iii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in subclause (II), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending

on or before the date of enactment of this paragraph, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAM OR ESTABLISHMENT OF NEW PROGRAM.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program or the establishment of a new residency training program that is not reflected on the most recent cost report that has been settled (or, if not, submitted (subject to audit)), after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary.

"(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2010, made available under this paragraph, as determined by the Secretary.

"(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall distribute the increase to hospitals based on the following criteria:

"(i) The Secretary shall give preference to hospitals that submit applications for new primary care and general surgery residency positions. In the case of any increase based on such preference, a hospital shall ensure that—

''(I) the position made available as a result of such increase remains a primary care or general surgery residency position for not less than 10 years after the date on which the position is filled; and

''(II) the total number of primary care and general surgery residency positions in the hospital (determined based on the number of such positions as of the date of such increase, including any position added as a result of such increase) is not decreased during such 10-year period.

In the case where the Secretary determines that a hospital no longer meets the requirement of subclause (II), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph.

''(ii) The Secretary shall give preference to hospitals that emphasizes training in community health centers and other community-based clinical settings.

''(iii) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios). In determining the number of medical students in a State for purposes of the preceding sentence, the Secretary shall include planned students at medical schools which have provisional accreditation by the Liaison Committee on Medical Education or the American Osteopathic Association.

''(iv) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

''(E) LIMITATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(III)) apply for more than 50 full-time equivalent

additional residency positions under this paragraph.

''(ii) INCREASE IN NUMBER OF ADDITIONAL POSITIONS AVAILABLE FOR DISTRIBUTION.—The Secretary shall increase the number of full-time equivalent additional residency positions a hospital may apply for under this paragraph if the Secretary determines that the number of additional residency positions available for distribution under subparagraph (A)(ii) exceeds the number of such applications approved.

''(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(G) DISTRIBUTION.—The Secretary shall distribute the increase to hospitals under this

paragraph not later than 2 years after the date of enactment of this paragraph.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after the date of enactment of this clause, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

SEC. 2327. COUNTING RESIDENT TIME IN OUTPATIENT SETTINGS.

(a) D–GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking ''under an approved medical residency training program''; and

(2) by striking ''if the hospital incurs all, or substantially all, of the costs for the training program in that setting'' and inserting ''if the hospital continues to incur the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting''.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended—

(1) by striking ''under an approved medical residency training program''; and

(2) by striking ''if the hospital incurs all, or substantially all, of the costs for the training program in that setting'' and inserting ''if the hospital continues to incur the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Effective for cost reporting periods beginning on or after July 1, 2009, the Sec-

retary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after July 1, 2009.

(2) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 2328. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 2327(a), is amended—

(1) in paragraph (4)(E)—

(A) by designating the first sentence as a clause (i) with the heading ''IN GENERAL'' and appropriate indentation and by striking ''Such

rules'' and inserting ''Subject to clause (ii), such rules''; and

(B) by adding at the end the following new clause:

''(ii) TREATMENT OF CERTAIN NON-HOSPITAL AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonhospital setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.'';

(2) in paragraph (4), by adding at the end the following new subparagraph:

''(I) In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical resi-

dency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(3) in paragraph (5), by adding at the end the following new subparagraph:

''(M) NONHOSPITAL SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonhospital setting that is primarily engaged in furnishing patient care' means a nonhospital setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 2326(b), is amended by adding at the end the following new clause:

''(xi)(I) The provisions of subparagraph (I) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

''(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

''(aa) is recognized as a subsection (d) hospital;

''(bb) is recognized as a subsection (d) Puerto Rico hospital;

''(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by

the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(xi)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(4) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of

the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 2329. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED AND ACQUIRED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)) is amended by adding at the end the following new clauses:

''(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

''(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital with an approved medical residency program closes on or after the date of enactment of the Balanced Budget Act of 1997, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

''(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in

determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals located in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

"(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

"(bb) Second, to hospitals located in the same State as the hospital that closed.

"(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

"(dd) Fourth, to all other hospitals.

"(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

"(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

"(vii) SPECIAL RULE FOR ACQUIRED HOSPITALS.—

"(I) IN GENERAL.—In the case of a hospital that is acquired (through any mechanism) by another entity with the approval of a bankruptcy court, during a period determined by

the Secretary (but not less than 3 years), the applicable resident limit of the acquired hospital shall, except as provided in subclause (II), be the applicable resident limit of the hospital that was acquired (as of the date immediately before the acquisition), without regard to whether the acquiring entity accepts assignment of the Medicare provider agreement of the hospital that was acquired, so long as the acquiring entity continues to operate the hospital that was acquired and to furnish services, medical residency programs, and volume of patients similar to the services, medical residency programs, and volume of patients of the hospital that was acquired (as determined by the Secretary) during such period.

''(II) LIMITATION.—Subclause (I) shall only apply in the case where an acquiring entity waives the right as a new provider under the program under this title to have the otherwise

applicable resident limit of the acquired hospital re-established or increased.''.

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, as amended by section 2326(b), is amended by striking ''subsections (h)(7) and (h)(8)'' and inserting ''subsections (h)(4)(H)(vi), (h)(4)(H)(vii), (h)(7), and (h)(8)''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

(d) NO AFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The amendments made by this section shall not affect any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act).

SEC. 2330. QUALITY IMPROVEMENT ORGANIZATION ASSISTANCE FOR PHYSICIAN PRACTICES SEEKING TO BE PATIENT-CENTERED MEDICAL HOME PRACTICES.

Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall revise the 9th Statement of Work under the Quality Improvement Program under part B of title XI of the Social Security Act to include a requirement that, in order to be an eligible Quality Improvement Organization (in this section referred to as a ''QIO'') for the 9th Statement of Work contract cycle, a QIO shall provide assistance, including technical assistance, to physicians under the Medicare program under title XVIII of the Social Security Act that seek to acquire the elements necessary to be recognized as a patient-centered medical home practice under the National Committee for Quality Assurance's Physician Practice Connections—PCMH module (or any successor module issued by such Committee).

Subtitle D—Studies

SEC. 2401. STUDY CONCERNING THE DESIGNATION OF PRIMARY CARE AS A SHORTAGE PROFESSION.

(a) IN GENERAL.—Not later than June 30, 2010, the Secretary of Labor shall conduct a study and submit to the Committee on Education and Labor of the House of

Representatives and the Committee on Health, Education, Labor, and Pensions a report that contains—

(1) a description of the criteria for the designation of primary care physicians as professions in shortage as defined by the Secretary under section 212(a)(5)(A) of the Immigration and Nationality Act;

(2) the findings of the Secretary on whether primary care physician professions will, on the date on which the report is submitted, or within the 5-year period beginning on such date, satisfy the criteria referred to in paragraph (1); and

(3) if the Secretary finds that such professions will not satisfy such criteria, recommendations for modifications to such criteria to enable primary care physicians to be so designated as a profession in shortage.

(b) REQUIREMENTS.—In conducting the study under subsection (a), the Secretary of Labor shall consider workforce data from the Health Resources and Services Administration, the Council on Graduate Medical Education, the Association of American Medical Colleges, and input from physician membership organizations that represent primary care physicians.

SEC. 2402. STUDY CONCERNING THE EDUCATION DEBT OF MEDICAL SCHOOL GRADUATES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to evaluate the higher education-related indebtedness of medical school graduates in the United States at the time of graduation from medical school, and the impact of such indebtedness on specialty choice, including the impact on the field of primary care.

(b) REPORT.—

(1) SUBMISSION AND DISSEMINATION OF REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit a report on the study required by subsection (a) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor of the House of Representatives, and shall make such report widely available to the public.

(2) ADDITIONAL REPORTS.—The Comptroller General may periodically prepare and release as necessary additional reports on the topic described in subsection (a).

SEC. 2403. STUDY ON MINORITY REPRESENTATION IN PRIMARY CARE.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Administrator of the Health

Resources and Services Administration, shall conduct a study of minority representation in training, and in practice, in primary care specialties.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall submit to the appropriate committees of Congress a report concerning the study conducted under subsection (a), including recommendations for achieving a primary care workforce that is more representative of the population of the United States.

TITLE III—MEDICARE PAYMENT PROVISIONS

SEC. 3001. SHORT TITLE.

This title may be cited as the ''Medicare Payment Improvement Act of 2009''.

SEC. 3002. FINDINGS.

Congress makes the following findings:

(1) The health care delivery system must be realigned to provide better clinical outcomes, safety, and patient satisfaction at lower cost. This should be a common goal for all health care professionals, hospitals, and other groups. Today's reimbursement system pays the most to those who perform the most

services, and therefore can provide disincentives to efficient and high-quality providers.

(2) The regional inequities in Medicare reimbursement penalize areas that have cost-effective health care delivery systems and reward those States that have high utilization rates and provide inefficient care.

(3) According to the Dartmouth Health Atlas, over the past 10 years, a number of studies have explored the relationship between higher spending and the quality and outcomes of care. The findings are remarkably consistent, concluding that higher spending does not result in better quality of care.

(4) New payment models should be developed to move away from paying for quantity and instead paying for improving health and truly rewarding effective and efficient care.

SEC. 3003. VALUE INDEX UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(e)(5) of the Social Security Act (42 U.S.C. 1395w–4(e)) is amended by adding at the end the following new paragraph:

''(6) VALUE INDEX.—

''(A) IN GENERAL.—The Secretary shall determine a value index for each fee schedule

area. The value index shall be the ratio of the quality component under subparagraph (B) to the cost component under subparagraph (C) for that fee schedule area.

''(B) QUALITY COMPONENT.—

''(i) IN GENERAL.—The quality component shall be based on a composite score that reflects quality measures available on a State or fee schedule area basis. The measures shall reflect health outcomes and health status for the Medicare population, patient safety, and patient satisfaction. The Secretary shall use the best data available, after consultation with the Agency for Healthcare Research and Quality and with private entities that compile quality data.

''(ii) ADVISORY GROUP.—

''(I) IN GENERAL.—Not later than 60 days after the date of enactment of the Medicare Payment Improvement Act of 2009, the Secretary shall establish a group of experts and stakeholders to make consensus recommendations to the Secretary re-

garding development of the quality component. The membership of the advisory group shall at least reflect providers, purchasers, health plans, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality.

''(II) DUTIES.—In the development of recommendations with respect to the quality component, the group established under subclause (I) shall consider at least the following areas:

''(aa) High cost procedures as determined by data under this title.

''(bb) Health outcomes and functional status of patients.

''(cc) The continuity, management, and coordination of health care and care transitions, including episodes of care, for patients across the continuum of providers, health care settings, and health plans.

"(dd) Patient, caregiver, and authorized representative experience, quality and relevance of information provided to patients, caregivers, and authorized representatives, and use of information by patients, caregivers, and authorized representatives to inform decision making.

"(ee) The safety, effectiveness, and timeliness of care.

"(ff) The appropriate use of health care resources and services.

"(gg) Other items determined appropriate by the Secretary.

"(iii) REQUIREMENT.—In establishing the quality component under this subparagraph, the Secretary shall—

"(I) take into account the recommendations of the group established under clause (ii)(I); and

"(II) provide for an open and transparent process for the activities

conducted pursuant to the convening of such group with respect to the development of the quality component.

''(iv) ESTABLISHMENT.—The quality component for each fee schedule area shall be the ratio of the quality score for such area to the national average quality score.

''(v) QUALITY BASELINE.—If the quality component for a fee schedule area does not rank in the top 25th percentile as compared to the national average (as determined by the Secretary) and the amount of reimbursement for services under this section is greater than the amount of reimbursement for such services that would have applied under this section if the amendments made by section 2 of the Medicare Payment Improvement Act of 2009 had not been enacted, this section shall be applied as if such amendments had not been enacted.

''(vi) APPLICATION.—In the case of a fee schedule area that is less than an entire State, if available quality data is not sufficient to measure quality at the sub-

State level, the quality component for a sub-State fee schedule area shall be the quality component for the entire State.

''(C) COST COMPONENT.—

''(i) IN GENERAL.—The cost component shall be total annual per beneficiary Medicare expenditures under part A and this part for the fee schedule area. The Secretary may use total per beneficiary expenditures under such parts in the last two years of life as an alternative measure if the Secretary determines that such measure better takes into account severity differences among fee schedule areas.

''(ii) ESTABLISHMENT.—The cost component for a fee schedule area shall be the ratio of the cost per beneficiary for such area to the national average cost per beneficiary.''.

(b) CONFORMING AMENDMENTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(1)(C), by striking ''geographic'' and inserting ''geographic and value''; and

(2) in subsection (e)—

(A) in paragraph (1)—

(i) in the heading, by inserting ''AND VALUE'' after ''GEOGRAPHIC'';

(ii) in subparagraph (A), by striking clause (iii) and inserting the following new clause:

''(iii) a value index (as defined in paragraph (6)) applicable to physician work.'';

(iii) in subparagraph (C), by inserting ''and value'' after ''geographic'' in the first sentence;

(iv) in subparagraph (D), by striking ''physician work effort'' and inserting ''value'';

(v) by striking subparagraph (E); and

(vi) by striking subparagraph (G);

(B) by striking paragraph (2) and inserting the following new paragraph:

''(2) COMPUTATION OF GEOGRAPHIC AND VALUE ADJUSTMENT FACTOR.—For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic and value adjustment factor equal to the sum of the geographic cost-of-practice adjustment

factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the value adjustment factor (specified in paragraph (5)) for the service and the area.''; and

(C) by striking paragraph (5) and inserting the following new paragraph:

''(5) PHYSICIAN WORK VALUE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the 'physician work value adjustment factor' for a service for a fee schedule area, is the product of—

''(A) the proportion of the total relative value for the service that reflects the relative value units for the work component; and

''(B) the value index score for the area, based on the value index established under paragraph (6).''.

(c) AVAILABILITY OF QUALITY COMPONENT PRIOR TO IMPLEMENTATION.—The Secretary of Health and Human Services shall make the quality component described in section 1848(c)(6)(B) of the Social Security Act, as added by subsection (a), for each fee schedule area available to the public by not later than July 1, 2011.

(d) EFFECTIVE DATE.—Subject to subsection (e), the amendments made by this section shall apply to the

Medicare physician fee schedule for 2012 and each subsequent year.

(e) TRANSITION.—Notwithstanding the amendments made by the preceding provisions of this section, the Secretary of Health and Human Services shall provide for an appropriate transition to the amendments made by this section. Under such transition, in the case of payments under such fee schedule for services furnished during—

(1) 2012, 25 percent of such payments shall be based on the amount of payment that would have applied to the services if such amendments had not been enacted and 75 percent of such payment shall be based on the amount of payment that would have applied to the services if such amendments had been fully implemented;

(2) 2013, 50 percent of such payment shall be based on the amount of payment that would have applied to the services if such amendments had not been enacted and 50 percent of such payment shall be based on the amount of payment that would have applied to the services if such amendments had been fully implemented; and

(3) 2014 and subsequent years, 100 percent of such payment shall be based on the amount of payment that is applicable under such amendments.

TITLE IV—LONG-TERM SERVICES PROVISIONS

SEC. 4001. SHORT TITLE.

This title may be cited as the ''Home and Community Balanced Incentives Act of 2009''.

Subtitle A—Balancing Incentives

SEC. 4101. ENHANCED FMAP FOR EXPANDING THE PROVISION OF NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.

(a) ENHANCED FMAP TO ENCOURAGE EXPANSION.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in the first sentence of subsection (b)—

(A) by striking '', and (4)'' and inserting '', (4)''; and

(B) by inserting before the period the following: '', and (5) in the case of a balancing incentive payment State, as defined in subsection (y)(1), that meets the conditions described in subsection (y)(2), the Federal medical assistance percentage shall be increased by the applicable number of percentage points determined under subsection (y)(3) for the State with respect to medical assistance described in subsection (y)(4)''; and

(2) by adding at the end the following new subsection:

''(y) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—For purposes of clause (5) of the first sentence of subsection (b):

''(1) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

''(A) in which less than 50 percent of the total expenditures for medical assistance for fiscal year 2009 for long-term services and supports (as defined by the Secretary, subject to paragraph (5)) are for non-institutionally-based long-term services and supports described in paragraph (5)(B);

''(B) that submits an application and meets the conditions described in paragraph (2); and

''(C) that is selected by the Secretary to participate in the State balancing incentive payment program established under this subsection.

''(2) CONDITIONS.—The conditions described in this paragraph are the following:

''(A) APPLICATION.—The State submits an application to the Secretary that includes the following:

''(i) A description of the availability of non-institutionally-based long-term services and supports described in paragraph (5)(B) available (for fiscal years beginning with fiscal year 2009).

''(ii) A description of eligibility requirements for receipt of such services.

''(iii) A projection of the number of additional individuals that the State expects to provide with such services to during the 5-fiscal-year period that begins with fiscal year 2011.

''(iv) An assurance of the State's commitment to a consumer-directed long-term services and supports system that values quality of life in addition to quality of care and in which beneficiaries are empowered to choose providers and direct their own care as much as possible.

''(v) A proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-

based long-term services and supports described in paragraph (5)(B) during such 5-fiscal-year period, and that includes—

"(I) a description of the new or expanded offerings of such services that the State will provide; and

"(II) the projected costs of the services identified in subclause (I).

"(vi) A description of how the State intends to achieve the target spending percentage applicable to the State under subparagraph (B).

"(vii) An assurance that the State will not use Federal funds, revenues described in section 1903(w)(1), or revenues obtained through the imposition of beneficiary cost-sharing for medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B) for the non-Federal share of expenditures for medical assistance described in paragraph (4).

"(B) TARGET SPENDING PERCENTAGES.—

"(i) In the case of a balancing incentive payment State in which less than 25

percent of the total expenditures for home and community-based services under the State plan and the various waiver authorities for fiscal year 2009 are for such services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for home and community-based services under the State plan and the various waiver authorities are for such services.

''(ii) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for home and community-based services under the State plan and the various waiver authorities are for such services.

''(C) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B))

that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

''(D) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this subsection only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in paragraph (5)(B) (including expansion through offering such services to increased numbers of beneficiaries of medical assistance under this title).

''(E) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits and application under this paragraph, such changes to the administration of the State plan (and, if applicable, to waivers approved for the State that involve the provision of long-term care services and supports) as the Secretary determines, by regulation or otherwise, are essential to achieving an improved balance between the provision of non-institutionally-based long-term services and supports described in paragraph (5)(B) and other long-

term services and supports, and which shall include the following:

"(i) 'NO WRONG DOOR'—SINGLE ENTRY POINT SYSTEM.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that—

"(I) shall require such agency, organization, network, or portal to provide—

"(aa) consumers with information regarding the availability of such services, how to apply for such services, and other referral services; and

"(bb) information regarding, and make recommendations for, providers of such services; and

"(II) may, at State option, permit such agency, organization, network, or portal to—

"(aa) determine financial and functional eligibility for such services and supports; and

"(bb) provide or refer eligible individuals to services and supports otherwise available in the community (under programs other than the State program under this title), such as housing, job training, and transportation.

"(ii) PRESUMPTIVE ELIGIBILITY.—At the option of the State, provision of a 60-day period of presumptive eligibility for medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B) for any individual whom the State has reason to believe will qualify for such medical assistance (provided that any expenditures for such medical assistance during such period are disregarded for purposes of determining the rate of erroneous excess payments for medical assistance under section 1903(u)(1)(D)).

''(iii) CASE MANAGEMENT.—Development, in accordance with guidance from the Secretary, of conflict-free case management services to—

''(I) address transitioning from receipt of institutionally-based long-term services and supports described in paragraph (5)(A) to receipt of non-institutionally-based long-term services and supports described in paragraph (5)(B); and

''(II) in conjunction with the beneficiary, assess the beneficiary's needs and , if appropriate, the needs of family caregivers for the beneficiary, and develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the caregivers) in directing the provision of services and supports, for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

''(iv) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in paragraph (5)(B), which shall be used in a uniform manner throughout the State, to—

''(I) assess a beneficiary's eligibility and functional level in terms of relevant areas that may include medical, cognitive, and behavioral status, as well as daily living skills, and vocational and communication skills;

''(II) based on the assessment conducted under subclause (I), determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs;

''(III) conduct ongoing monitoring based on the service plan; and

''(IV) require reporting of collect data for purposes of comparison among different service models.

''(F) DATA COLLECTION.—Collecting from providers of services and through such other means as the State determines appropriate the following data:

''(i) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in paragraph (5)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

''(ii) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

''(iii) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the

State that are accessible to providers and include—

"(I) measures of beneficiary and family caregiver experience with providers;

"(II) measures of beneficiary and family caregiver satisfaction with services; and

"(III) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

"(3) APPLICABLE NUMBER OF PERCENTAGE POINTS INCREASE IN FMAP.—The applicable number of percentage points are—

"(A) in the case of a balancing incentive payment State subject to the target spending percentage described in paragraph (2)(B)(i), 5 percentage points; and

"(B) in the case of any other balancing incentive payment State, 2 percentage points.

"(4) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), medical assistance described in this paragraph is medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B) that is provided during the period that begins on October 1, 2011, and ends on September 30, 2015.

''(B) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this subsection during the period described in subparagraph (A), or to a State to which paragraph (6) of the first sentence of subsection (b) applies, exceed $3,000,000,000.

''(5) LONG-TERM SERVICES AND SUPPORTS DEFINED.—In this subsection, the term 'long-term services and supports' has the meaning given that term by Secretary and shall include the following:

''(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:

''(i) Nursing facility services.

"(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15).

"(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not provided in an institution, including the following:

"(i) Home and community-based services provided under subsection (c), (d), or (i), of section 1915 or under a waiver under section 1115.

"(ii) Home health care services.

"(iii) Personal care services.

"(iv) Services described in subsection (a)(26) (relating to PACE program services).

"(v) Self-directed personal assistance services described in section 1915(j)".

(b) ENHANCED FMAP FOR CERTAIN STATES TO MAINTAIN THE PROVISION OF HOME AND COMMUNITY-BASED SERVICES.—The first sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)), as amended by subsection (a), is amended—

(1) by striking ", and (5)" and inserting ", (5)"; and

(2) by inserting before the period the following: '', and (6) in the case of a State in which at least 50 percent of the total expenditures for medical assistance for fiscal year 2009 for long-term services and supports (as defined by the Secretary for purposes of subsection (y)) are for non-institutionally-based long-term services and supports described in subsection (y)(5)(B), and which satisfies the requirements of subparagraphs (A) (other than clauses (iii), (v), and (vi)), (C), and (F) of subsection (y)(2), and has implemented the structural changes described in each clause of subparagraph (E) of that subsection, the Federal medical assistance percentage shall be increased by 1 percentage point with respect to medical assistance described in subparagraph (A) of subsection (y)(4) (but subject to the limitation described in subparagraph (B) of that subsection)''.

(c) GRANTS TO SUPPORT STRUCTURAL CHANGES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall award grants to States for the following purposes:

(A) To support the development of common national set of coding methodologies and databases related to the provision of non-institutionally-based long-term services and supports

described in paragraph (5)(B) of section 1905(y) of the Social Security Act (as added by subsection (a)).

(B) To make structural changes described in paragraph (2)(E) of section 1905(y) to the State Medicaid program.

(2) PRIORITY.—In awarding grants for the purpose described in paragraph (1)(A), the Secretary of Health and Human Services shall give priority to States in which at least 50 percent of the total expenditures for medical assistance under the State Medicaid program for fiscal year 2009 for long-term services and supports, as defined by the Secretary for purposes of section 1905(y) of the Social Security Act, are for non-institutionally-based long-term services and supports described in paragraph (5)(B) of such section.

(3) COLLABORATION.—States awarded a grant for the purpose described in paragraph (1)(A) shall collaborate with other States, the National Governor's Association, the National Conference of State Legislatures, the National Association of State Medicaid Directors, the National Association of State Directors of Developmental Disabilities, and other appropriate organizations in developing speci-

fications for a common national set of coding methodologies and databases.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2012.

(d) AUTHORITY FOR INDIVIDUALIZED BUDGETS UNDER WAIVERS TO PROVIDE HOME AND COMMUNITY-BASED SERVICES.—In the case of any waiver to provide home and community-based services under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n) or section 1115 of such Act (42 U.S.C. 1315), that is approved or renewed after the date of enactment of this Act, the Secretary of Health and Human Services shall permit a State to establish individualized budgets that identify the dollar value of the services and supports to be provided to an individual under the waiver.

(e) OVERSIGHT AND ASSESSMENT.—

(1) DEVELOPMENT OF STANDARDIZED REPORTING REQUIREMENTS.—

(A) STANDARDIZATION OF DATA AND OUTCOME MEASURES.—The Secretary of Health and Human Services shall consult with States and the National Governor's Association, the National Conference of State Legislatures, the

National Association of State Medicaid Directors, the National Association of State Directors of Developmental Disabilities, and other appropriate organizations to develop specifications for standardization of—

(i) reporting of assessment data for long-term services and supports (as defined by the Secretary for purposes of section 1905(y)(5) of the Social Security Act) for each population served, including information standardized for purposes of certified EHR technology (as defined in section 1903(t)(3)(A) of the Social Security Act (42 U.S.C. 1396b(t)(3)(A)) and under other electronic medical records initiatives; and

(ii) outcomes measures that track assessment processes for long-term services and supports (as so defined) for each such population that maintain and enhance individual function, independence, and stability.

(2) ADMINISTRATION OF HOME AND COMMUNITY SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to en-

sure that all States develop service systems that are designed to—

(A) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports described in paragraph (5)(B) of section 1905(y) of the Social Security Act (as added by subsection (a)) (including such services and supports that are provided under programs other the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence;

(B) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

(C) improve coordination among all providers of such services under federally and State-funded programs in order to—

(i) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(ii) oversee and monitor all service system functions to assure—

(I) coordination of, and effectiveness of, eligibility determinations and individual assessments; and

(II) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations.

(3) MONITORING.—The Secretary of Health and Human Services shall assess on an ongoing basis and based on measures specified by the Agency for Healthcare Research and Quality, the safety and quality of non-institutionally-based long-term services and supports described in paragraph (5)(B) of section 1905(y) of that Act provided to beneficiaries of such services and supports and the outcomes with regard to such beneficiaries' experiences with such services. Such oversight shall include examination of—

(A) the consistency, or lack thereof, of such services in care plans as compared to those services that were actually delivered; and

(B) the length of time between when a beneficiary was assessed for such services, when the care plan was completed, and when the beneficiary started receiving such services.

(4) GAO STUDY AND REPORT.—The Comptroller General of the United States shall study the longitudinal costs of Medicaid beneficiaries receiving long-term services and supports (as defined by the Secretary for purposes of section 1905(y)(5) of the Social Security Act) over 5-year periods across various programs, including the non-institutionally-based long-term services and supports described in paragraph (5)(B) of such section, PACE program services under section 1894 of the Social Security Act (42 U.S.C. 1395eee, 1396u–4), and services provided under specialized MA plans for special needs individuals under part C of title XVIII of the Social Security Act.

Subtitle B—Strengthening the Medicaid Home and Community-Based State Plan Amendment Option

SEC. 4201. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES UNDER STATE PLAN AMENDMENT OPTION FOR INDIVIDUALS IN NEED.

(a) PARITY WITH INCOME ELIGIBILITY STANDARD FOR INSTITUTIONALIZED INDIVIDUALS.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by striking ''150 percent of the poverty line (as defined in section 2110(c)(5))'' and inserting ''300 percent of the supplemental security income benefit rate established by section 1611(b)(1)''.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

''(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

''(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt

of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

''(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

"(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

"(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

"(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

"(B) 5-YEAR TERM.—

"(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

"(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

"(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

"(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

''(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.''.

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking ''or such other services requested by the State as the Secretary may approve''.

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking ''or'' at the end;

(B) in subclause (XIX), by adding ''or'' at the end; and

(C) by inserting after subclause (XIX), the following new subclause:

''(XX) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i),

or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A), by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) in clause (xii), by striking ''or'' at the end;

(ii) in clause (xiii), by adding ''or'' at the end; and

(iii) by inserting after clause (xiii) the following new clause:

''(xiv) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section

1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,''.

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

''(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.''; and

(2) in subclause (II) of subparagraph (D)(ii), by striking ''to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services'' and inserting ''to continue to be eligible for

such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria''.

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking ''1902(a)(1) (relating to statewideness)'' and inserting ''1902(a)(10)(B) (relating to comparability)''.

(g) EFFECTIVE DATE.—The amendments made by this section take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 4202. MANDATORY APPLICATION OF SPOUSAL IMPOVERISHMENT PROTECTIONS TO RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amended by striking ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)'' and inserting ''is eligible for medical assistance for home and community-based services under subsection (c), (d), (e), or (i) of section 1915''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2009.

SEC. 4203. STATE AUTHORITY TO ELECT TO EXCLUDE UP TO 6 MONTHS OF AVERAGE COST OF NURSING FACILITY SERVICES FROM ASSETS OR RESOURCES FOR PURPOSES OF ELIGIBILITY FOR HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended by adding at the end the following new subsection:

''(i) STATE AUTHORITY TO EXCLUDE UP TO 6 MONTHS OF AVERAGE COST OF NURSING FACILITY SERVICES FROM HOME AND COMMUNITY-BASED SERVICES ELIGIBILITY DETERMINATIONS.—Nothing in this section or any other provision of this title, shall be construed as prohibiting a State from excluding from any determination of an individual's assets or resources for purposes of determining the eligibility of the individual for medical assistance for home and community-based services under subsection (c), (d), (e), or (i) of section 1915 (if a State imposes an limitation on assets or resources for purposes of eligibility for such services), an amount equal to the product of the amount applicable under subsection (c)(1)(E)(ii)(II) (at the time such determination is made)

and such number, not to exceed 6, as the State may elect.''.

(b) RULE OF CONSTRUCTION.—Nothing in the amendment made by subsection (a) shall be construed as affecting a State's option to apply less restrictive methodologies under section 1902(r)(2) for purposes of determining income and resource eligibility for individuals specified in that section.

Subtitle C—Coordination of Home and Community-Based Waivers

SEC. 4301. STREAMLINED PROCESS FOR COMBINED WAIVERS UNDER SUBSECTIONS (B) AND (C) OF SECTION 1915.

Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall create a template to streamline the process of approving, monitoring, evaluating, and renewing State proposals to conduct a program that combines the waiver authority provided under subsections (b) and (c) of section 1915 of the Social Security Act (42 U.S.C. 1396n) into a single program under which the State provides home and community-based services to individuals based on individualized assessments and care plans (in this section referred to as the ''combined waivers program''). The tem-

plate required under this section shall provide for the following:

(1) A standard 5-year term for conducting a combined waivers program.

(2) Harmonization of any requirements under subsections (b) and (c) of such section that overlap.

(3) An option for States to elect, during the first 5-year term for which the combined waivers program is approved to phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

(4) Examination by the Secretary, prior to each renewal of a combined waivers program, of how well the State has—

(A) adhered to the combined waivers program requirements; and

(B) performed in meeting the State's objectives for the combined waivers program, including with respect to quality improvement and beneficiary outcomes.

TITLE V—HOME AND COMMUNITY-BASED SERVICES PROVISIONS

SEC. 5001. SHORT TITLE.

This Act may be cited as the ''Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009''.

SEC. 5002. LONG-TERM SERVICES AND SUPPORTS.

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following:

''TITLE XXII—LONG-TERM SERVICES AND SUPPORTS

''SEC. 2201. DEFINITIONS.

''Except as otherwise provided, the terms used in this title have the meanings given the terms in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002).

''Subtitle A—Single-Entry Point System Program

''SEC. 2211. STATE SINGLE-ENTRY POINT SYSTEMS.

''(a) DEFINITIONS.—In this title:

''(1) LONG-TERM SERVICES AND SUPPORTS.—The term 'long-term services and supports' means any service (including a disease prevention and health promotion service, an in-home service, or a

case management service), care, or item (including an assistive device) that is—

"(A) intended to assist individuals in coping with, and, to the extent practicable, compensating for, functional impairment in carrying out activities of daily living;

"(B) furnished at home, in a community care setting, including a small community care setting (as defined in section 1929(g)(1)) and a large community care setting (as defined in section 1929(h)(1)), or in a long-term care facility; and

"(C) not furnished to diagnose, treat, or cure a medical disease or condition.

"(2) SINGLE-ENTRY POINT SYSTEM.—The term 'single-entry point system' means any coordinated system for providing—

"(A) comprehensive information to consumers and caregivers on the full range of available public and private long-term services and supports, options, service providers, and resources, including information on the availability of integrated long-term care, including consumer directed care options;

''(B) personal counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances; and

''(C) consumers and caregivers access to the range of publicly supported and privately supported long-term services and supports that are available.

''(b) PROGRAM.—The Secretary shall establish and carry out a single-entry point system program. In carrying out the program, the Secretary shall make grants to States, from allotments described in subsection (c), to pay for the Federal share of the cost of establishing State single-entry point systems.

''(c) ALLOTMENTS.—

''(1) ALLOTMENTS TO INDIAN TRIBES AND TERRITORIES.—

''(A) RESERVATION.—The Secretary shall reserve from the funds made available under subsection (g)—

''(i) for fiscal year 2010, $1,962,456; and

''(ii) for each subsequent fiscal year, $1,962,456, increased by the percentage increase in the Consumer Price Index for All Urban Consumers, between October of the fiscal year preceding the subsequent fiscal year and October 2007.

''(B) ALLOTMENTS.—The Secretary shall use the funds reserved under subparagraph (A) to make allotments to—

''(i) Indian tribes; and

''(ii) Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands.

''(2) ALLOTMENTS TO STATES.—

''(A) IN GENERAL.—

''(i) AMOUNT.—The Secretary shall allot to each eligible State for a fiscal year the sum of the fixed amount determined under subparagraph (B), and the allocation determined under subparagraph (C), for the State.

''(ii) SUBGRANTS TO AREA AGENCIES ON AGING.—

"(I) IN GENERAL.—Each State agency receiving an allotment under clause (i) shall use such allotment to make subgrants to area agencies on aging that can demonstrate performance capacity to carry out activities described in this section whether such area agency on aging carries out the activities directly or through contract with an aging network or disability entity.

"(II) SUBGRANTS TO OTHER ENTITIES.—A State agency may make subgrants described in subclause (I) to other qualified aging network or disability entities only if the area agency on aging chooses not to apply for a subgrant or is not able to demonstrate performance capacity to carry out the activities described in this section.

"(III) SUBGRANTEE RECIPIENT SUBGRANTS.—An administrator of a single-entry point system established by a State receiving an allotment

under clause (i) shall make any necessary subgrants to key partners involved in developing, planning, or implementing the single-entry point system. Such partners may include centers for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)).

''(B) FIXED AMOUNTS FOR STATES.—

''(i) RESERVATION.—The Secretary shall reserve from the funds made available under subsection (g)—

''(I) for fiscal year 2010, $15,759,000; and

''(II) for each subsequent fiscal year, $15,759,000, increased by the percentage increase in the Consumer Price Index for All Urban Consumers, between October of the fiscal year preceding the subsequent fiscal year and October 2007.

''(ii) FIXED AMOUNTS.—The Secretary shall use the funds reserved under clause (i) to provide equal fixed amounts to the States.

''(C) ALLOCATION FOR STATES.—The Secretary shall allocate to each eligible State for a fiscal year an amount that bears the same relationship to the funds made available under subsection (g) (and not reserved under paragraph (1) or subparagraph (B)) for that fiscal year as the number of persons who are either older individuals or individuals with disabilities in that State bears to the number of such persons or individuals in all the States.

''(D) DETERMINATION OF NUMBER OF PERSONS.—

''(i) OLDER INDIVIDUALS.—The number of older individuals in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the Bureau of the Census, and other reliable demographic data satisfactory to the Secretary.

''(ii) INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the American Community Survey,

and other reliable demographic data satisfactory to the Secretary, on individuals who have a sensory disability, physical disability, mental disability, self-care disability, go-outside-home disability, or employment disability.

''(3) ELIGIBILITY.—In addition to the States determined by the Secretary to be eligible for a grant under this section, a State that receives a Federal grant for an aging and disability resource center is eligible for a grant under this section.

''(4) DEFINITION.—In this subsection, the term 'State' shall not include any jurisdiction described in paragraph (1)(B)(ii).

''(d) APPLICATIONS.—

''(1) IN GENERAL.—To be eligible to receive an initial grant under this section, a State agency shall, after consulting and coordinating with consumers, other stakeholders, and area agencies on aging in the State, if any, submit an application to the Secretary at such time, in such manner, and containing the following information:

''(A) Evidence of substantial involvement of stakeholders and agencies in the State that

are administering programs that will be the subject of referrals.

''(B) The applicant shall establish or designate a collaborative board to ensure meaningful involvement of stakeholders in the development, planning, implementation, and evaluation of a single-entry point system consistent with the following:

''(i) The collaborative board shall be composed of—

''(I) individuals representing all populations served by the applicant's single-entry point system, including older adults and individuals from diverse backgrounds who have a disability or a chronic condition requiring long-term support;

''(II) a representative from the local center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)), and representatives from other organizations that provide services to the individuals served by the system and

those who advocate on behalf of such individuals; and

''(III) representatives of the government and non-governmental agencies that are affected by the system.

''(ii) The applicant shall work in conjunction with the collaborative board on—

''(I) the design and operations of the single-entry point system;

''(II) stakeholder input; and

''(III) other program and policy development issues related to the single-entry point system.

''(iii) An advisory board established under the Real Choice Systems Change Program or for an existing single-entry point system may be used to carry out the activities of a collaborative board under this subparagraph if such advisory board meets the requirements under clause (i).

''(C) The applicant's plan for providing—

''(i) comprehensive information on the full range of available public and private long-term services and supports options, providers, and resources, including building

awareness of the single-entry point system as a resource;

''(ii) objective, neutral, and personal information, counseling, and assistance to individuals and their caregivers in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care to meet their needs;

''(iii) for eligibility screening and referral for services;

''(iv) for stakeholder input;

''(v) for a management information system; and

''(vi) for an evaluation of the effectiveness of the single-entry point system.

''(D) A specification of the period of the grant request, which shall include not less than 3 consecutive fiscal years in the 5-fiscal-year period beginning with fiscal year 2010.

''(E) Such other information as the Secretary determines appropriate.

''(2) APPLICATION FOR CONTINUATION.—

''(A) IN GENERAL.—A State that receives an initial grant under this section shall apply,

after consulting and coordinating with the area agencies on aging, for a continuation of the initial grant, which includes a description of any significant changes to the information provided in the initial application and such data concerning performance measures related to the requirements in the initial application as the Secretary shall require.

''(B) EFFECT.—The requirement under subparagraph (A) shall be in effect through fiscal year 2020.

''(e) USE OF FUNDS.—

''(1) IN GENERAL.—A State that receives a grant under this section shall use the funds made available through the grant to—

''(A) establish a State single-entry point system, to enable older individuals and individuals with disabilities and their caregivers to obtain resources concerning long-term services and supports options; and

''(B) provide information on, access to, and assistance regarding long-term services and supports.

''(2) SERVICES.—In particular, the State single-entry point system shall be the referral source to—

''(A) provide information about long-term care planning and available long-term services and supports through a variety of media (such as websites, seminars, and pamphlets);

''(B) provide assistance with making decisions about long-term services and supports and determining the most appropriate services through options counseling, future financial planning, and case management;

''(C) provide streamlined access to and assistance with applying for federally funded long-term care benefits (including medical assistance under title XIX, Medicare skilled nursing facility services, services under title III of the Older Americans Act of 1965 (42 U.S.C. 3021 et seq.), the services of Aging and Disability Resource Centers), and State-funded and privately funded long-term care benefits, through efforts to shorten and simplify the eligibility processes for older individuals and individuals with disabilities;

''(D) provide referrals to the State evidence-based disease prevention and health promotion programs under subtitle B;

''(E) allocate the State funds available under subtitle C and carry out the State enhanced nursing home diversion program under subtitle C; and

''(F) and provide information about, other services available in the State that may assist an individual to remain in the community, including the Medicare and Medicaid programs, the State health insurance assistance program, the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), and the Low-Income Home Energy Assistance Program under the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8621 et seq.), and such other services, as the State shall include.

''(3) COLLABORATIVE ARRANGEMENTS.—

''(A) CENTER FOR INDEPENDENT LIVING.—Each entity receiving an allotment under subsection (c) shall involve in the planning and implementation of the single-entry point system the local center for independent living (as de-

fined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)), which provides information, referral, assistance, or services to individuals with disabilities.

''(B) OTHER ENTITIES.—To the extent practicable, the State single-entry point system is encouraged to enter into collaborative arrangements with aging and disability programs, service providers, agencies, the direct care work force, and other entities in order to ensure that information about such services may be made available to individuals accessing the State single-entry point system.

''(f) FEDERAL SHARE.—

''(1) IN GENERAL.—The Federal share of the cost described in subsection (b) shall be 75 percent.

''(2) NON-FEDERAL SHARE.—The State may provide the non-Federal share of the cost in cash or in-kind, fairly evaluated, including plant, equipment, or services. The State may provide the non-Federal share from State, local, or private sources.

''(g) FUNDING.—

''(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (2) to make the grants described in subsection (b).

''(2) FUNDING.—There are authorized to be appropriated to carry out this section—

''(A) $30,900,000 for fiscal year 2010;

''(B) $38,264,000 for fiscal year 2011;

''(C) $48,410,000 for fiscal year 2012;

''(D) $53,560,000 for fiscal year 2013;

''(E) $63,860,000 for fiscal year 2014;

''(F) $69,010,000 for fiscal year 2015;

''(G) $74,160,000 for fiscal year 2016;

''(H) $79,310,000 for fiscal year 2017;

''(I) $84,460,000 for fiscal year 2018;

''(J) $89,610,000 for fiscal year 2019; and

''(K) $95,790,000 for fiscal year 2020.

''(3) AVAILABILITY.—Funds appropriated under paragraph (2) shall remain available until expended.

''Subtitle B—Healthy Living Program

''SEC. 2221. EVIDENCE-BASED DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS.

''(a) PROGRAM.—The Secretary shall establish and carry out a healthy living program. In carrying out the program, the Secretary shall make grants to State agencies, from allotments described in subsection (b), to pay

for the Federal share of the cost of carrying out evidence-based disease prevention and health promotion programs.

''(b) ALLOTMENTS.—

''(1) ALLOTMENTS TO INDIAN TRIBES AND TERRITORIES.—

''(A) RESERVATION.—The Secretary shall reserve from the funds made available under subsection (g)—

''(i) for fiscal year 2010, $1,500,952; and

''(ii) for each subsequent fiscal year, $1,500,952, increased by the percentage increase in the Consumer Price Index for All Urban Consumers, between October of the fiscal year preceding the subsequent fiscal year and October 2007.

''(B) ALLOTMENTS.—The Secretary shall use the reserved funds under subparagraph (A) to make allotments to—

''(i) Indian tribes; and

''(ii) Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands.

''(2) IN GENERAL.—

''(A) AMOUNTS.—

''(i) IN GENERAL.—Except as provided in paragraph (3), the Secretary shall allot to each eligible State for a fiscal year an amount that bears the same relationship to the funds made available under this section and not reserved under paragraph (1) for that fiscal year as the number of older individuals in the State bears to the number of older individuals in all the States.

''(ii) OLDER INDIVIDUALS.—The number of older individuals in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the Bureau of the Census, and other reliable demographic data satisfactory to the Secretary.

''(B) SUBGRANTS.—

''(i) IN GENERAL.—Each State agency that receives an amount under subparagraph (A) shall award subgrants to area agencies on aging that can demonstrate performance capacity to carry out activities under this section whether such area agen-

cy on aging carries out the activities directly or through contract with an aging network entity.

"(ii) SUBGRANTS TO OTHER ENTITIES.—A State agency may make subgrants described in clause (i) to other qualified aging network entities only if the area agency on aging chooses not to apply for a subgrant or is not able to demonstrate performance capacity to carry out the activities described in this section.

"(3) MINIMUM ALLOTMENT.—No State shall receive an allotment under this section for a fiscal year that is less than 0.5 percent of the funds made available to carry out this section for that fiscal year and not reserved under paragraph (1).

"(4) ELIGIBILITY.—In addition to the States determined by the Secretary to be eligible for a grant under this section, a State that receives a Federal grant for evidence-based disease prevention is eligible for a grant under this section.

"(c) APPLICATIONS.—To be eligible to receive a grant under this section, a State agency shall, after consulting and coordinating with consumers, other stakeholders, and area agencies on aging in the State, if any, submit an ap-

plication to the Secretary at such time, in such manner, and containing the following information:

''(1) A description of the evidence-based disease prevention and health promotion program.

''(2) Sufficient information to demonstrate that the infrastructure exists to support the program.

''(3) A specification of the period of the grant request, which shall include not less than 3 consecutive fiscal years in the 5-fiscal-year period beginning with fiscal year 2010.

''(4) Such other information as the Secretary determines appropriate.

''(d) APPLICATION FOR CONTINUATION.—

''(1) IN GENERAL.—A State that receives an initial grant under this section shall apply, after consulting and coordinating with the area agencies on aging, for a continuation of the initial grant, which application shall include—

''(A) a description of any significant changes to the information provided in the initial application; and

''(B) such data concerning performance measures related to the requirements in the initial application as the Secretary shall require.

''(2) EFFECT.—The requirement under paragraph (1) shall be in effect through fiscal year 2020.

''(e) USE OF FUNDS.—A State that receives a grant under this section shall use the funds made available through the grant to carry out—

''(1) an evidence-based chronic disease self-management program;

''(2) an evidence-based falls prevention program; or

''(3) another evidence-based disease prevention and health promotion program.

''(f) FEDERAL SHARE.—

''(1) IN GENERAL.—The Federal share of the cost described in subsection (a) shall be 85 percent.

''(2) NON-FEDERAL SHARE.—The State may provide the non-Federal share of the cost in cash or in-kind, fairly evaluated, including plant, equipment, or services. The State may provide the non-Federal share from State, local, or private sources.

''(g) FUNDING.—

''(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (2) to make the grants described in subsection (a).

''(2) FUNDING.—There are authorized to be appropriated to carry out this section—

''(A) $36,050,000 for fiscal year 2010;

''(B) $41,200,000 for fiscal year 2011;

''(C) $56,650,000 for fiscal year 2012;

''(D) $77,250,000 for fiscal year 2013;

''(E) $92,700,000 for fiscal year 2014;

''(F) $103,000,000 for fiscal year 2015;

''(G) $118,450,000 for fiscal year 2016;

''(H) $133,900,000 for fiscal year 2017;

''(I) $149,350,000 for fiscal year 2018;

''(J) $157,590,000 for fiscal year 2019; and

''(K) $173,040,000 for fiscal year 2020.

''(3) AVAILABILITY.—Funds appropriated under paragraph (2) shall remain available until expended.

''Subtitle C—Diversion Programs

''SEC. 2231. ENHANCED NURSING HOME DIVERSION PROGRAMS.

''(a) DEFINITION.—In this section:

''(1) LOW-INCOME SENIOR.—The term 'low-income senior' means an individual who—

''(A) is age 75 or older; and

''(B) is from a household with a household income that is not less than 150 percent, and not more than 300 percent, of the poverty line.

''(2) NURSING HOME.—The term 'nursing home' means—

''(A) a skilled nursing facility, as defined in section 1819(a); or

''(B) a nursing facility, as defined in section 1919(a).

''(b) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish and carry out a diversion program. In carrying out the program, the Secretary shall make grants to States, from allotments described in subsection (c), to pay for the Federal share of the cost of carrying out enhanced nursing home diversion programs.

''(2) COHORTS.—The Secretary shall make the grants to—

''(A) a first year cohort consisting of one third of the States, for fiscal year 2010;

''(B) a second year cohort consisting of the cohort described in subparagraph (A) and an additional one third of the States, for fiscal year 2011; and

''(C) a third year cohort consisting of all the eligible States, for fiscal year 2012 and each subsequent fiscal year.

''(3) READINESS.—In determining whether to include an eligible State in the first year, second year, or third year and subsequent year cohort, the Secretary shall consider the readiness of the State to carry out an enhanced nursing home diversion program under this section. Readiness shall be determined based on a consideration of the following factors:

''(A) Availability of a comprehensive array of home and community-based services.

''(B) Sufficient home and community-based services provider capacity.

''(C) Availability of housing.

''(D) Availability of supports for consumer-directed services, including whether a fiscal intermediary is in place.

''(E) Ability to perform timely eligibility determinations and assessment for services.

''(F) Existence of a quality assessment and improvement program for home and community-based services.

''(G) Such other factors as the Secretary determines appropriate.

''(c) ALLOTMENTS.—

''(1) IN GENERAL.—

''(A) AMOUNT.—The Secretary shall allot to an eligible State (within the applicable cohort) for a fiscal year an amount that bears the same relationship to the funds made available under subsection (i) for that fiscal year as the number of low-income seniors in the State bears to the number of low-income seniors within States in the applicable cohort for that fiscal year.

''(B) LOW-INCOME SENIORS.—The number of low-income seniors in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the American Community Survey, and other reliable demographic data satisfactory to the Secretary.

''(2) ELIGIBILITY.—In addition to the States determined by the Secretary to be eligible for a grant under this section, a State that receives a Federal grant for a nursing home diversion is eligible for a grant under this section.

''(d) APPLICATIONS.—To be eligible to receive a grant under this section, a State agency shall, after consulting and coordinating with consumers, other stakeholders, and area agencies on aging in the State, if any,

submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a specification of the period of the grant request, which shall include not less than 3 consecutive fiscal years in the 5-fiscal-year period beginning with the fiscal year prior to the year of application.

''(e) APPLICATION FOR CONTINUATION.—

''(1) IN GENERAL.—A State that receives an initial grant under this section shall apply, after consulting and coordinating with the area agencies on aging, for a continuation of the initial grant, which application shall include—

''(A) a description of any significant changes to the information provided in the initial application; and

''(B) such data concerning performance measures related to the requirements in the initial application as the Secretary shall require.

''(2) EFFECT.—The requirement under paragraph (1) shall be in effect through fiscal year 2020.

''(f) USE OF FUNDS.—

''(1) IN GENERAL.—A State that receives a grant under this section shall carry out the following:

''(A) Use the funds made available through the grant to carry out an enhanced nursing home diversion program that enables eligible individuals to avoid admission into nursing homes by enabling the individuals to obtain alternative long-term services and supports and remain in their communities.

''(B) Award subgrants to area agencies on aging that can demonstrate performance capacity to carry out activities under this section whether such area agency on aging carries out the activities directly or through contract with an aging network entity. A State may make subgrants to other qualified aging network entities only if the area agency on aging chooses not to apply for a subgrant or is not able to demonstrate performance capacity to carry out the activities described in this section.

''(2) CASE MANAGEMENT.—

''(A) IN GENERAL.—The State, through the State single-entry point system established under subtitle A, shall provide for case management services to the eligible individuals.

''(B) USE OF EXISTING SERVICES.—In carrying out subparagraph (A), the State agen-

cy or area agency on aging may utilize existing case management services delivery networks if—

"(i) the networks have adequate safeguards against potential conflicts of interest; and

"(ii) the State agency or area agency on aging includes a description of such safeguards in the grant application.

"(C) CARE PLAN.—The State shall provide for development of a care plan for each eligible individual served, in consultation with the eligible individual and their caregiver, as appropriate. In developing the care plan, the State shall explain the option of consumer directed care and assist an individual, who so requests, with developing a consumer-directed care plan that shall include arranging for support services and funding. Such assistance shall include providing information and outreach to individuals in the hospital, in a nursing home for post-acute care, or undergoing changes in their health status or caregiver situation.

"(g) ELIGIBLE INDIVIDUALS.—In this section, the term 'eligible individual' means an individual—

''(1) who has been determined by the State to be at high functional risk of nursing home placement, as defined by the State agency in the State agency's grant application;

''(2) who is not eligible for medical assistance under title XIX; and

''(3) who meets the income and asset eligibility requirements established by the State and included in such State's grant application for approval by the Secretary.

''(h) FEDERAL SHARE.—

''(1) IN GENERAL.—The Federal share of the cost described in subsection (b) shall be, for a State and for a fiscal year, the sum of—

''(A) the Federal medical assistance percentage applicable to the State for the year under section 1905(b); and

''(B) 5 percentage points.

''(2) NON-FEDERAL SHARE.—The State may provide the non-Federal share of the cost in cash or in-kind, fairly evaluated, including plant, equipment, or services. The State may provide the non-Federal share from State, local, or private sources.

''(i) FUNDING.—

''(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (2) to make the grants described in subsection (b).

''(2) FUNDING.—There are authorized to be appropriated to carry out this section—

''(A) $111,825,137 for fiscal year 2010;

''(B) $337,525,753 for fiscal year 2011;

''(C) $650,098,349 for fiscal year 2012;

''(D) $865,801,631 for fiscal year 2013;

''(E) $988,504,887 for fiscal year 2014;

''(F) $1,124,547,250 for fiscal year 2015;

''(G) $1,276,750,865 for fiscal year 2016;

''(H) $1,364,488,901 for fiscal year 2017;

''(I) $1,466,769,052 for fiscal year 2018;

''(J) $1,712,755,702 for fiscal year 2019; and

''(K) $1,712,755,702 for fiscal year 2020.

''(3) AVAILABILITY.—Funds appropriated under paragraph (2) shall remain available until expended.

"Subtitle D—Administration, Evaluation, and Technical Assistance

"SEC. 2241. ADMINISTRATION, EVALUATION, AND TECHNICAL ASSISTANCE.

''(a) ADMINISTRATION AND EXPENSES.—For purposes of carrying out this title, there are authorized to be appropriated for administration and expenses—

''(1) of the area agencies on aging—

''(A) $16,825,895 for fiscal year 2010;

''(B) $39,246,141 for fiscal year 2011;

''(C) $50,766,948 for fiscal year 2012;

''(D) $66,999,101 for fiscal year 2013;

''(E) $76,979,152 for fiscal year 2014;

''(F) $87,163,513 for fiscal year 2015;

''(G) $98,780,562 for fiscal year 2016;

''(H) $106,063,792 for fiscal year 2017;

''(I) $114,324,642 for fiscal year 2018;

''(J) $123,312,948 for fiscal year 2019; and

''(K) $133,215,845 for fiscal year 2020;

''(2) of the State agencies—

''(A) $8,412,948 for fiscal year 2010;

''(B) $19,623,071 for fiscal year 2011;

''(C) $25,383,474 for fiscal year 2012;

"(D) $33,499,551 for fiscal year 2013;

"(E) $38,489,576 for fiscal year 2014;

"(F) $43,581,756 for fiscal year 2015;

"(G) $49,390,281 for fiscal year 2016;

"(H) $53,031,896 for fiscal year 2017;

"(I) $57,162,321 for fiscal year 2018;

"(J) $61,656,474 for fiscal year 2019; and

"(K) $66,607,923 for fiscal year 2020; and

"(3) of the Administration—

"(A) $2,103,237 for fiscal year 2010;

"(B) $4,905,768 for fiscal year 2011;

"(C) $6,345,868 for fiscal year 2012;

"(D) $8,374,888 for fiscal year 2013;

"(E) $9,622,394 for fiscal year 2014;

"(F) $10,895,439 for fiscal year 2015;

"(G) $12,347,570 for fiscal year 2016;

"(H) $13,257,974 for fiscal year 2017;

"(I) $14,290,580 for fiscal year 2018;

"(J) $15,414,118 for fiscal year 2019; and

"(K) $16,651,981 for fiscal year 2020.

"(b) EVALUATION AND TECHNICAL ASSISTANCE.—

"(1) CONDITIONS TO RECEIPT OF GRANT.—In awarding grants under this title, the Secretary shall condition receipt of the grant for the second and

subsequent grant years on a satisfactory determination that the State agency is meeting benchmarks specified in the grant agreement for each grant awarded under this title.

''(2) EVALUATIONS.—The Secretary shall measure and evaluate, either directly or through grants or contracts, the impact of the programs authorized under this title. Not later than June 1 of the year that is 6 years after the year of the date of enactment of the Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009 and every 2 years thereafter, the Secretary shall—

''(A) compile the reports of the measures and evaluations of the grantees;

''(B) establish benchmarks to show progress toward savings; and

''(C) present a compilation of the information under this paragraph to Congress.

''(3) TECHNICAL ASSISTANCE GRANTS.—The Secretary shall award technical assistance grants, including State-specific grants whenever practicable, to carry out the programs authorized under this title.

''(4) TRANSFER.—There are authorized to be appropriated for such evaluation and technical assistance under this subsection—

''(A) $4,206,474 for fiscal year 2010;

''(B) $9,811,535 for fiscal year 2011;

''(C) $8,461,158 for fiscal year 2012;

''(D) $11,166,517 for fiscal year 2013;

''(E) $12,829,859 for fiscal year 2014;

''(F) $14,527,252 for fiscal year 2015;

''(G) $16,463,427 for fiscal year 2016;

''(H) $17,677,299 for fiscal year 2017;

''(I) $19,054,107 for fiscal year 2018;

''(J) $20,552,158 for fiscal year 2019; and

''(K) $22,202,641 for fiscal year 2020.

''(c) AVAILABILITY.—Funds appropriated under this section shall remain available until expended.''.

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